

Missouri Medicaid Psychology/Counseling Billing Book



Missouri Department of Social Services
Division of Medical Services

Published by the Provider Education Unit

PREFACE

This psychology/counseling training booklet contains information to help providers submit claims correctly. The information is only for Missouri Medicaid providers and billers if the provider's Medicaid provider number begins with "49". The booklet is not all-inclusive of program benefits and limitations; providers should refer to specific program manuals for the entire content.

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Missouri Medicaid Psychology/Counseling Billing Book

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SECTION 1

MEDICAID PROGRAM RESOURCES

Informational Resources available at www.dss.mo.gov/dms

CONTACTING MEDICAID

PROVIDER COMMUNICATIONS

The following phone numbers are available for Medicaid providers to call the Provider Communications Unit with provider inquiries, concerns or questions regarding proper claim filing, claims resolution and disposition, and recipient eligibility questions and verification. The toll free line provides an interactive voice response system that can answer questions regarding matters including recipient eligibility, last two check amounts, and claim status. Providers must use a touchtone phone to access the system.

Provider Communications	800/392-0938
Interactive Voice Response (IVR)	800/392-0938
Standard Line	573/751-2896

The Provider Communications Unit also processes written inquiries. Written inquiries should be sent to:

Provider Communications Unit
Division of Medical Services
P.O. Box 6500
Jefferson City, Missouri 65102

INFOCROSSING HEALTHCARE SERVICES HELP DESK **573/635-3559**

Call this number for assistance in establishing the required electronic claims and remittance advice formats, network communication, HIPAA trading partner agreements, and assistance with the Infocrossing Internet billing service.

PROVIDER ENROLLMENT

Providers can contact Provider Enrollment via email as follows for questions regarding enrollment applications: providerenrollment@mail.medicaid.state.mo.us

Changes regarding address, ownership, tax identification number, name (provider or practice), or Medicare number must be submitted in writing to:

Provider Enrollment Unit
Division of Medical Services
P.O. Box 6500
Jefferson City, Missouri 65102

THIRD PARTY LIABILITY

573/751-2005

Call the Third Party Liability Unit to report injuries sustained by Medicaid recipients, problems obtaining a response from an insurance carrier, or unusual situations concerning third party insurance coverage for a Medicaid patient.

PROVIDER EDUCATION

573/751-6683

Provider Education Unit staff are available to educate providers and other groups on proper billing methods and procedures for Medicaid claims. Contact the Unit for training information and scheduling.

RECIPIENT SERVICES

800/392-2161 or 573/751-6527

The Recipient Services Unit assists recipients regarding access to providers, eligibility, covered and non-covered services, and unpaid medical bills.

MEDICAID EXCEPTIONS AND DRUG PRIOR AUTHORIZATION HOTLINE

800/392-8030

Providers can call this toll free number to initiate an emergency request for an essential medical service or an item of equipment that would not normally be covered under the Medicaid program, or to request a drug prior authorization. The Medicaid exceptions fax line for non-emergency requests only is 573/636-6470.

**HEALTH INSURANCE PORTABILITY AND
ACCOUNTABILITY ACT (HIPAA) INFORMATION**

Billing providers who want to exchange electronic information transactions with Missouri Medicaid can access the *HIPAA Companion Guide* online by going to the Division of Medical Services webpage at www.dss.mo.gov/dms and clicking on “manuals” under the Provider Information heading.

To access the *X12N Version 4010A1 Companion Guide*: 1) select Missouri Medicaid Electronic Billing Layout Manuals; 2) select System Manuals; 3) select Electronic Claims Layout Manuals; and, 4) select X12N Version 4010A1 Companion Guide.

For information on the Missouri Medicaid Trading Partner Agreement: 1) select Section 1 - Getting Started; and, 2) select Trading Partner Registration.

All questions concerning the Trading Partner Agreement or provider testing schedules are to be directed to the Infocrossing Help Desk, 573-635-3559.

INTERACTIVE VOICE RESPONSE (IVR)

800/392-0938

The Provider Communications Unit toll-free number, 800/392-0938 is answered by an Interactive Voice Response (IVR) unit, which requires a touchtone phone. The nine-digit Medicaid provider number **must** be entered each time any of the IVR options are accessed. Callers are limited to ten inquiries per call on any of the options. Providers whose numbers are inactive may utilize the IVR only for dates of service during their active status.

- Option 1 Recipient Eligibility
Recipient eligibility **must** be verified **each** time a recipient presents and should be verified **prior** to the service. Eligibility information can be obtained by a recipient's Medicaid number (DCN), social security number and date of birth; or if a newborn, using the mother's Medicaid number and the baby's date of birth. Callers cannot inquire on dates that exceed one year prior to the current date. Callers will be given a confirmation number and this number should be kept as proof of the information received.
- Option 2 Last Two Check Amounts
Using this option, the caller will be given the last two Remittance Advice (RA) dates, RA numbers, and check amounts.
- Option 3 Claim Status
After entering the recipient's Medicaid number (DCN) and the date of service, the caller will be provided the status of the most current claim in the system containing the date of service entered. The caller will be told whether the claim is paid, denied, approved to pay or is being processed. In addition, the system will give the amount paid, the RA date and the Internal Control Number (ICN).
- Option 4 Not currently in use.
- Option 5 Medicaid Information Messages
The caller will be given the option to select from several recorded messages providing the latest information regarding the Medicaid program.
- Option 6 Prior Authorization – Will not give status of Psychology PA
This option allows pharmacy providers to verify the status of a prior authorization for an NDC (National Drug Code).

INTERNET SERVICES FOR MEDICAID PROVIDERS

The Division of Medical Services (DMS), in cooperation with Infocrossing Healthcare Services, has an Internet service for Missouri Medicaid providers. Missouri Medicaid providers have the ability to:

- Submit claims and receive claim confirmation files;
- Verify recipient eligibility;
- Obtain remittance advices (RAs);
- Submit adjustments;
- Submit attachments; and
- View and download public files.

The web site address for this service is www.emomed.com. Without proper authorization, providers are unable to access the site. Only providers who are approved to be electronic billers can enroll and utilize the website services. To participate in the service, the provider must apply on-line at <http://www.medicaid.state.mo.us/Application.html>. Each user is required to complete this on-line application in order to obtain a user ID and password. The application process only takes a few minutes and provides the applicant with a real-time confirmation response, user ID, and password. Once the user ID and password have been received, the user can begin using the www.emomed.com website. The password can be changed to one of the user's own choice.

Questions regarding the completion of the on-line Internet application should be directed to the Infocrossing Healthcare Services Help Desk, (573) 635-3559.

An authorization is required for each individual person within a provider's office or a billing service who will be accessing the Internet site.

This website, www.emomed.com, allows for the submission of the following HIPAA compliant transactions:

837 Institutional Claims	Batched or Individual
837 Professional Claims	Batched or Individual
837 Dental Claims	Batched or Individual
270 Eligibility Inquiry	Batched or Individual
276 Claim Status Inquiry	Batched or Individual

The following standard responses are generated:

835 Remittance Advice	Batch or Printable RA
271 Eligibility Response	Batch or Individual
277 Claim Status Response	Batch or Individual

Users also have access to provider check amounts and the Claims Processing Schedule for the current fiscal year.

There is no cost for this service except for the cost of an Internet service provider access to the Internet. Additionally, there are no special software requirements. However, the user (provider) must have the proper web browser. The provider must have one of the following web browsers: Internet Explorer 6.0 or higher or Netscape 7.0 or higher. It is strongly recommended that users update and utilize the most recent versions of either of these browser programs. The Internet site is available 24 hours a day, 7 days a week with the exception of being down for scheduled maintenance.

VERIFYING RECIPIENT ELIGIBILITY THROUGH THE INTERNET

Providers can access Missouri Medicaid recipient eligibility files via the website. Functions include eligibility verification by recipient ID, casehead ID and child's date of birth, or Social Security number and date of birth. Eligibility verification can be performed on an individual basis or in a batch file. Individual eligibility verification occurs in real-time basis similar to the Interactive Voice Response System, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.

A batch eligibility confirmation file can either be downloaded for viewing purposes or to be printed.

MEDICAID CLAIMS SUBMISSION THROUGH THE INTERNET

The following claim types, as defined by HIPAA Transaction and Code Set regulations, can be used for Internet claim submissions:

- < 837 - Health Care Claim
 - Professional
 - Dental
 - Institutional (hospital inpatient and outpatient, nursing home, and home health care)
- < Pharmacy (NCPDP)

The field requirements and filing instructions are similar to those for paper claim submissions. For the provider's convenience, some of the claim input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

A batch claim confirmation file can either be downloaded for viewing purposes or to be printed.

NOTE: Currently, some claims cannot be submitted electronically if an attachment is required unless the attachment is one of the following that can be submitted via the Infocrossing Internet service: Sterilization Consent, Second Surgical Opinion, Acknowledgment of the Receipt of Hysterectomy Information or the PI 118 Referral forms.

OBTAINING A REMITTANCE ADVICE THROUGH THE INTERNET

The Medicaid program phased out the mailing of paper Remittance Advices (RAs). Providers no longer receive both paper and electronic RAs. If the provider or the provider's billing service currently receive an electronic RA, (either via the emomed.com Internet website or other method), paper copies of the RA were discontinued as of the July 20, 2004 financial cycle. All providers and billers must have Internet access to obtain the printable electronic RA via the Infocrossing Internet service, emomed.com.

Receiving the remittance advice via the Internet is beneficial to the provider's or biller's operation. With the new Internet RA, a user can:

- Retrieve the RA the Monday following the weekend claim processing cycle (two weeks sooner than receipt of the paper RA);
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from the desktop; and,
- Download the RA into the provider's or biller's operating system for retrieval at a later date.

The new Internet RA is viewable and printable in a ready to use format. Just point and click to print the RA or save it to the computer system for printing at the user's convenience.

To sign up for this service, see the instructions at the beginning of this information on Internet services. If a provider does not have access to the Internet, contact the Infocrossing Help Desk, (573) 635-3559, to learn how to obtain a paper remittance advice.

ADJUSTMENTS THROUGH THE INTERNET

Providers have options on the Internet Medical, Dental, Inpatient, Outpatient and Nursing Home claims for a "Frequency Code" that will allow either a 7 - Replacement (Adjustment) or an 8 - Void (Credit). This will control an individual adjustment or void, but not group adjustments or voids. Claim adjustments and credits can be submitted by utilizing the CLM, field CLMO5-3, segment of the 837 Health Care Claim.

RECEIVE PUBLIC FILES THROUGH THE INTERNET

Several public files are available for viewing or downloading from the website including the claims processing schedule for the State fiscal year which begins July 1 and ends June 30. Providers also have access to a listing of HIPAA related claim codes and other HIPAA related codes.

SUBMIT ATTACHMENTS AND FORMS THROUGH THE INTERNET

Providers can submit required attachments and forms via the Internet as an option to mailing paper versions to Medicaid. A paper copy of any attachment or form submitted via the Internet must be kept with the patient's record. The following forms can be submitted through the Infocrossing Internet Service:

Sterilization Consent,
Second Surgical Opinion,
PI 118 Referral (administrative lock-in), and
Acknowledgment of Receipt of Hysterectomy Information.

MISSOURI MEDICAID PROVIDER MANUALS ON-LINE
www.dss.mo.gov/dms

How To Download/Print a Provider Manual

The following information assumes you are using a Microsoft Windows based operating system as your operating system. In order to be able to download and use all or a portion of an on-line Medicaid provider manual, you must have Adobe Acrobat Reader. If you already have this on your computer, you may disregard the first section and go directly to the sections detailing how to download and print the manuals.

NOTE: The provider manual information you download is current as of the time it is downloaded. Since periodic updates are made to the manuals, you must do a new download periodically so that your file will have the new or updated information.

A. Accessing and downloading Adobe Acrobat Reader program.

1. Open the DMS home page at www.dss.mo.gov/dms.
2. Scroll down, click on and open the line/link titled "Missouri Medicaid Provider Manuals".
3. In the newly opened page, scroll down and click on the yellow and red box at the bottom of the page titled "Get Acrobat Reader".
4. Once you have opened the Adobe Acrobat page, follow the instructions to download the free Adobe Acrobat Reader program to your computer system. Generally, the program will be installed in the C:/programs folder although you can put it in any folder you want.

B. Downloading and saving all or portions of a provider manual.

1. Go to the DMS home page at www.dss.mo.gov/dms.
2. Scroll down, click on and open the line/link titled "Missouri Medicaid Provider Manuals".
3. A new page will open. Click on the link titled "Missouri Medicaid Provider Manuals".

4. On the left side of the newly opened page, click on the “+” in front of the folder titled “Print A Manual” and click again on the subfolder. This opens a new frame in the upper right area of the screen titled “Print a Manual”. In this frame scroll down to the provider manual you want to access and click on the manual to open to its contents page. Disregard the frame in the lower area of the page titled “Search Results”.
5. When the page opens, it will display a number of links from which you can choose the one you want. The links allow you to access either the complete manual or sections of the selected manual.

For Internet Explorer Browser Users

For example, if you wish to download the entire physician's manual, place your pointer on the line/link titled "Complete Manual" and right click. A pop-up menu will appear. Click on the "Save Target As" button. Another pop window (Save As) will appear. Select where you want to save the file and its name. It can be saved either to a floppy disk or to a folder on the hard drive. If you rename the file, be sure to put the .pdf extension at the end of the new name. Click on the save button. The material then will be saved to the location/name you specified. Actual download time will vary depending on the file size of the information you want to download and the speed of your system's modem and your Internet service provider's system.

For Netscape Browser Users

For example, if you wish to download the entire physician's manual, place your pointer on the line/link titled "Complete Manual" and right click. A pop-up screen will appear. Click on "Save Link As". In the next pop-up window, select the drive/ folder where you want to save the date. You may rename the file, if you wish, a name other than the name presented by the system. Add or change the file extension to .pdf (at the end of the file name), e.g. change phyman to phyman.pdf. Click save and the data will be saved to the location/name you specified. Actual download time will vary depending on the file size of the information you want to download and the speed of your system's modem and your Internet service provider's system.

6. Close the screens all the way back to the browser. Close the browser screen and return to your desktop.

C. Using Adobe Acrobat Reader to access the saved manual file.

1. Open Acrobat Reader either using the desktop icon or the program file.
2. Once the work screen is open, click on "File" in the taskbar.
3. On the task screen, select and click on "Open".
4. Select and highlight the drive location and name of your file. Acrobat Reader will then open your file.
5. You now have the option of viewing or printing all or portions of the file.

D. Printing all or portions of an opened Acrobat Reader Document

1. Click on "File" on the taskbar.
2. On the task screen, select and click on "Print" or "Print Target".
3. You have three options for printing from the file. All - prints the entire file.
Current Page - prints only the page you have selected/highlighted. Pages - gives you the option to print a specified range of consecutive pages.
4. When the print command has been sent to the printer, select "File" on the taskbar and "Exit" in the task screen to exit the program and return to your desktop.

CLAIM AND ATTACHMENT MAILING ADDRESSES

Medicaid paper claims and attachments related to claims must be sent to the following address as indicated.

Infocrossing Healthcare Services, Inc.
P.O. Box (see below for correct PO box number)
Jefferson City, MO 65102

P.O. Box 5200..... RHC Claims
P.O. Box 5600..... DME, HCFA-1500, and Home Health Agency Claims
P.O. Box 4800..... Prior Authorization Requests

Infocrossing's physical address is: Infocrossing Healthcare Services, Inc.
905 Weathered Rock Road
Jefferson City, MO 65101

CLAIMS PROCESSING SCHEDULE FOR STATE FISCAL YEAR 2005

Cycle Run/Remittance Date* -

Friday, June 18, 2004
Friday, July 9, 2004
Friday, July 23, 2004
Friday, August 6, 2004
Friday, August 20, 2004
Friday, September 10, 2004
Friday, September 24, 2004
Friday, October 8, 2004
Friday, October 22, 2004
Friday, November 5, 2004
Friday, November 19, 2004
Friday, December 3, 2004
Friday, December 17, 2004
Friday, January 7, 2005
Friday, January 21, 2005
Friday, February 4, 2005
Friday, February 18, 2005
Friday, March 11, 2005
Friday, March 25, 2005
Friday, April 8, 2005
Friday, April 22, 2005
Friday, May 6, 2005
Friday, May 20, 2005
Friday, June 3, 2005

Check Date -

Tuesday, July 6, 2004
Tuesday, July 20, 2004
Thursday, August 5, 2004
Friday, August 20, 2004
Tuesday, September 7, 2004
Monday, September 20, 2004
Tuesday, October 5, 2004
Wednesday, October 20, 2004
Friday, November 5, 2004
Monday, November 22, 2004
Monday, December 6, 2004
Monday, December 20, 2004
Wednesday, January 5, 2005
Thursday, January 20, 2005
Monday, February 7, 2005
Monday, February 21, 2005
Monday, March 7, 2005
Monday, March 21, 2005
Tuesday, April 5, 2005
Wednesday, April 20, 2005
Thursday, May 5, 2005
Friday, May 20, 2005
Monday, June 6, 2005
Monday, June 20, 2005

*The Cycle Run Dates are tentative dates calculated by the Division of Medical Services. The dates are subject to change without prior notification.

*All claims submitted electronically to Infocrossing, must be received by 5:00 p.m. of the Cycle Run/Remittance Advice date in order to pay on the corresponding check date.

Holidays For State Fiscal Year 2005

July 5, 2004 Independence Day
September 6, 2004 Labor Day
October 11, 2004 Columbus Day
November 11, 2004 Veteran's Day
November 25, 2004 Thanksgiving
December 24, 2004 Christmas

December 31, 2004 New Years Day
January 17, 2005 Martin Luther King Day
February 11, 2005 Lincoln's Birthday
February 21, 2005 Washington's Birthday
May 9, 2005 Truman's Birthday
May 30, 2005 Memorial Day

SECTION 2

CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 claim form should be legibly printed by hand or electronically. It may be duplicated if the copy is legible. Medicaid paper claims should be mailed to:

Infocrossing Healthcare Services, Inc.
P.O. Box 5600
Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3 of the Medicaid *Providers Manual* available at www.dss.mo.gov/dms.

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

<u>Field number and name</u>	<u>Instructions for completion</u>
1.* Type of Health Insurance Coverage	Show the type of health insurance coverage applicable to this claim by checking the appropriate box. For example, if a Medicare claim is being filed, check the Medicare box, if a Medicaid claim is being filed, check the Medicaid box and if the patient has both Medicare and Medicaid, check both boxes.
1a.* Insured's I.D.	Enter the patient's eight-digit Medicaid or MC+ ID number (DCN) as shown on the patient's ID card.
2.* Patient's Name	Enter last name, first name, middle initial <i>in this order</i> as it appears on the ID card.
3. Patient's Birth Date Sex	Enter month, day, and year of birth. Mark appropriate box.
4.** Insured's Name	If there is individual or group insurance besides Medicaid, enter the name of the primary policyholder. If this field is completed, also complete fields 6, 7, 11, and 13. If no private insurance is involved, leave blank.
5. Patient's Address	Enter address and telephone number if available.

<u>Field number and name</u>	<u>Instructions for completion</u>
6.** Patient's Relationship to Insured	Mark appropriate box if there is other insurance. If no private insurance is involved, leave blank.
7.** Insured's Address	Enter the primary policyholder's address; enter policy-holder's telephone number, if available. If no private insurance is involved, leave blank.
8. Patient Status	Not required.
9.** Other Insured's Name	If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. If no private insurance is involved, leave blank. [See Note (1)]
9a.** Other Insured's Policy or Group Number	Enter the secondary policyholder's insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. If no private insurance is involved, leave blank. [See Note (1)]
9b.** Other Insured's Date of Birth	Enter the secondary policyholder's date of birth and mark the appropriate box reflecting the sex of the secondary policyholder. If no private insurance is involved, leave blank. [See Note (1)]
9c.** Employer's Name	Enter the secondary policyholder's employer's name. If no private insurance is involved, leave blank. [See Note (1)]
9d.** Insurance Plan	Enter the secondary policyholder's insurance plan name. If no private insurance is involved, leave blank. <i>If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. [See Note (1)]</i>

<u>Field number and name</u>	<u>Instructions for completion</u>
10a.-10c.** Is Condition Related to:	If services on the claim are related to patient's employment, an auto accident or other accident, mark the appropriate box. <i>If the services are not related to an accident, leave blank.</i> [See Note (1)]
10d. Reserved for Local Use	May be used for comments/descriptions.
11.** Insured's Policy or Group Number	Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. If no private insurance is involved, leave blank. [See Note (1)]
11a.** Insured's Date of Birth	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. If no private insurance is involved, leave blank. [See Note (1)]
11b.** Employer's Name	Enter the primary policyholder's employer name. If no private insurance is involved, leave blank. [See Note (1)]
11c.** Insurance Plan Name	Enter the primary policyholder's insurance plan name. <i>If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.</i> [See Note (1)]
11d.** Other Health Plan	Indicate whether the patient has a secondary health insurance plan. If so, complete fields 9-9d with the secondary insurance information. [See Note (1)]
12. Patient's Signature	Leave blank.
13. Insured's Signature	This field should be completed only when the patient has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the

<u>Field number and name</u>	<u>Instructions for completion</u>
	provider of Medicaid. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.
14.** Date of Current Illness, Injury or Pregnancy	This field is required when billing global prenatal and delivery services. The date should reflect the last menstrual period (LMP).
15. Date Same/Similar Illness	Leave blank.
16. Dates Patient Unable to Work	Leave blank.
17.** Name of Referring Physician or Other Source	Enter the name of the referring physician. If the physician is nonparticipating in the Missouri Medicaid Program, enter "nonparticipating." <i>This field is required for independent laboratories and independent radiology groups (provider types 70 and 71), and providers with a specialty of "30" (radiology/radiation therapy).</i>
17a.** I.D. Number of Referring Physician	Enter the referring physician's Medicaid provider number. If the physician is nonparticipating in the Missouri Medicaid Program, enter "nonparticipating." <i>This field is required for independent laboratories and independent radiology groups (provider types 70 and 71), and providers with a specialty of "30" (radiology/radiation therapy).</i>
18.** Hospitalization Dates	If the services on the claim were provided in an in-patient hospital setting, enter the admit and discharge dates. If the patient is still in the hospital at the time of filing, write "still" in the discharge date field or show the last date of in-patient service that is being billed in field 24a. This field is required when the service is performed on an in-patient basis.
19. Reserved for Local Use	Providers may use this field for additional remarks/descriptions.

<u>Field number and name</u>	<u>Instructions for completion</u>
20.** Lab Work Performed Outside Office	If billing for laboratory charges, mark the appropriate box. The referring physician may not bill for lab work that was referred out.
21.* Diagnosis	Enter the complete ICD-9-CM diagnosis code(s). Enter the primary diagnosis as No. 1, the secondary diagnosis as No. 2, etc.
22.** Medicaid Resubmission	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.
23. Prior Authorization Number	Leave blank.
24a.* Date of Service	Enter the date of service under “from” in month/day/year format, using a six-digit format. All line items must have a from date. A “to” date of service is required when billing on a single line for subsequent physician hospital visits on consecutive days.
24b.* Place of Service	Enter the appropriate place of service code. See Section 15.10 of the Medicaid <i>Physician’s Provider Manual</i> for the list of appropriate place of service codes.
24c. Type of Service	Leave blank.
24d.* Procedure Code	Enter the appropriate CPT or HCPCS code and applicable modifier(s), if any, corresponding to the service rendered. (Field 19 may be used for remarks or descriptions.) See Section 7 of this booklet for a list of modifiers used by the Missouri Medicaid program.
24e.* Diagnosis Code	Enter 1, 2, 3, 4 or the actual diagnosis code(s) from field 21.

<u>Field number and name</u>	<u>Instructions for completion</u>
24f.* Charges	Enter the provider's usual and customary charge for each line item. This should be the total charge if multiple days or units are shown.
24g.* Days or Units	Enter the number of days or units of service provided for each detail line. The system automatically plugs a "1" if the field is left blank.
24h.** EPSDT/Family Planning	If the service is an EPSDT/HCY screening service or referral, enter "E." If the service is family planning related, enter "FP." If the service is both an EPSDT/HCY and Family Planning service enter "B."
24i. Emergency	Leave blank.
24j. COB	Leave blank.
24k.** Performing Provider Number	This field is required only for a clinic (group practice), FQHC, public health agency, teaching institution or independent radiology group. Enter the Missouri Medicaid provider number of the physician or other professional who performed the service.
25. SS#/Fed. Tax ID	Leave blank.
26. Patient Account Number	For the provider's own information, a maximum of 12 alpha and/or numeric characters may be entered here.
27. Assignment	Not required on Medicaid claims.
28.* Total Charge	Enter the sum of the line item charges.
29.** Amount Paid	Enter the total amount received by all other insurance resources. Previous Medicaid payments, Medicare payments, cost sharing and co-pay amounts are not to be entered in this field.
30. Balance Due	Enter the difference between the total charge (field 28) and the insurance amount paid (field 29).

<u>Field number and name</u>	<u>Instructions for completion</u>
31. Provider Signature	Not Required.
32.** Name and Address of Facility	<p>If the services were rendered in a facility other than the home or office, enter the name and location of the facility.</p> <p>This field is required when the place of service is other than home or office.</p>
33.* Provider Name/ Number /Address	Affix the provider label or write or type the information exactly as it appears on the label.
* These fields are mandatory on all CMS-1500 claim form.	
** These fields are mandatory only in specific situations, as described.	
(1) NOTE: This field is for private insurance information only. If no private insurance is involved leave blank . If Medicare, Medicaid, employers name or other information appears in this field, the claim will deny. See Section 5 of the Medicaid <i>Provider's Manual</i> for further TPL (Third Party Liability) information.	

PLEASE
DO NOT
STAPLE
IN THIS
AREA

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM									
1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE)		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER		
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME		
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME		
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.		
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.									
SIGNED					DATE				
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.				
1. _____ 3. _____					23. PRIOR AUTHORIZATION NUMBER				
2. _____ 4. _____									
24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE									
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				
SIGNED					DATE				
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$				
					29. AMOUNT PAID \$				
					30. BALANCE DUE \$				
					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #				
					PIN# GRP#				

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

SECTION 3

THE REMITTANCE ADVICE

Missouri Medicaid discontinued printing and mailing paper Remittance Advices (RAs) to most providers effective July 20, 2004. The remittance advices now are available via the Internet through emomed.com. There are two versions available, the 837 format and the Printable RA.

With the implementation of Internet Remittance Advice, providers can:

- Retrieve a remittance advice the Monday following the weekend Financial Cycle run (two weeks sooner than the paper version);
- View and print the RA from your desktop; and
- Download the RA into your computer system for future reference.

More information on accessing and using the printable RA is found later in this section.

When a claim is adjudicated, it is included as a line item on the next RA. Along with listing the claim, the RA lists an “Adjustment Reason Code” to explain a payment, denial or other action. The Adjustment Reason Code is from a national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer’s reimbursement for it. The RA may also list a “Remittance Remark Code” which is from the same national administrative code set that indicates either a claim-level or service-level message that cannot be expressed with a claim Adjustment Reason Code. The Adjustment Reason Codes and Remittance Remark Codes may be found on the Division of Medical Services’ website, www.dss.mo.gov/dms, and clicking on the link “HIPAA related code lists”.

The date on the RA is the date the final processing cycle runs. Reimbursement will be made through a mailed check or a direct bank deposit approximately two weeks after the cycle run date. (See Claims Processing Schedule at the end of Section 1.)

The RA is grouped first by paid claims and then by denied claims. Claims in each category are listed alphabetically by the patient’s last name. If the patient’s name and/or Departmental Client Number (DCN) are **not** on file, only the first two letters of the last name and first letter of the first name appear.

Each claim entered into the claims processing system is assigned a 13-digit Internal Control Number (ICN) assigned for identification purposes. The first two digits of an ICN indicate the type of claim.

- 15 – Paper claim
- 18 – Paper Medicare Part B Crossover
- 40 – Electronic Medicare Crossover
- 49 – Internet claim

- 70 – Individual Credit to an Adjustment
- 50 – Individual Adjustment Request
- 75 – Credit Mass Adjustment
- 55 – Mass Adjustment

The third and fourth digits indicate the year the claim was received. The fifth, sixth, and seventh digits indicate the Julian date the claim was entered into the system. In the Julian system, the days are numbered consecutively from “001” (January 01) to “365” or “366” in a leap year (December 31). The last digits of an ICN are for internal processing.

The ICN 1504277315020 is read as a paper medical claim entered in the processing system on October 04, 2004.

If a claim is denied, a new or corrected claim form **must** be submitted as corrections **cannot** be made by submitting changes on the printed RA pages.

When a claim denies for other insurance, the commercial carrier information is shown. Up to two policies can be shown.

PRINTABLE REMITTANCE ADVICE

The Printable Internet Remittance Advice is accessed at www.emomed.com. A provider must be enrolled with [emomed.com](http://www.emomed.com) in order to access the website and the printable RA. To sign-up for [emomed.com](http://www.emomed.com) and the on-line Remittance Advice option, visit the Missouri Medicaid website, www.dss.mo.gov/dms, and select the Provider Information “internet access” link.

On the Printable Remittance Advice page, click on the RA date you wish to view, print or save and follow your Internet browser’s instructions. The RA is in the PDF file format. Your browser will open the file directly if you have Adobe Acrobat Reader installed on your computer. If you do not have this program, go to <http://www.adobe.com/products/acrobat/readsetp2.html> to download it to your computer.

RAs are available automatically following each financial cycle. Each RA remains available for a total of 62 days. The oldest RA drops off as the newest becomes available. Therefore, providers are encouraged to save each RA to their computer system for future reference and use.

Note: When printing an RA, it is set to page break after 70 lines per page.

If a provider did not save an RA to his/her computer and wants access to an RA that is no longer available, the provider can request the RA through the “Aged RA Request” link on the [emomed.com](http://www.emomed.com) home page.

In general, the Printable Remittance Advice is displayed as follows.

Field	Description
RECIPIENT NAME	The recipient's last name and first name. NOTE: If the recipient's name and identification number are <u>not</u> on file, only the first two letters of the last name and first letter of the first name appear.
MEDICAID ID	The recipient's 8-digit Medicaid identification number.
ICN	The 13-digit number assigned to the claim for identification purposes.
SERVICE DATES FROM	The initial date of service in MMDDYY format for the claim.
SERVICE DATES TO	The final date of service in MMDDYY format for the claim.
PAT ACCT	The provider's own patient account name or number.
CLAIM: ST	This field reflects the status of the claim. Values are: 1 = Processed as Primary, 3 = Processed as Tertiary, 4 = Denied, 22 = Reversal of Previous Payment
TOT BILLED	The total claim amount submitted.
TOT PAID	The total amount Medicaid paid on the claim.
TOT OTHER	The combined totals for patient liability (surplus), recipient copay, and spenddown total withheld.
LN	The line number of the billed service.
SERVICE DATES	The date of service(s) for the specific detail line.
REV/PROC/NDC	The submitted procedure code, NDC, or revenue code for the specific detail line. Note: The revenue code will only appear in this field if a procedure code is <u>not</u> present.
MOD	The submitted modifier(s) for the specific detail line.
REV CODE	The submitted revenue code for the specific detail line. Note: The revenue code only appears in this field if a procedure code has also been submitted.
QTY	The units of service submitted.
BILLED AMOUNT	The submitted billed amount for the specific detail line.
ALLOWED AMOUNT	The Medicaid maximum allowed amount for the procedure.
PAID AMOUNT	The amount Medicaid paid on the claim.
PERF PROV	The Medicaid ID number for the performing provider submitted at the detail.

Field	Description
SUBMITTER LN ITM CNTL	The submitted line item control number.
GROUP CODE	The Claim Adjustment Group Code is a code identifying the general category of payment adjustment. Values are: CO = Contractual Obligation CR = Correction and Reversals OA = Other Adjustment PI = Payer Initiated Reductions PR = Patient Responsibility
RSN	The Claim Adjustment Reason Code is the code identifying the detailed reason the adjustment was made.
AMT	The dollar amount adjusted for the corresponding reason code.
QTY	The adjustment to the submitted units of service. This field will not be printed if the value is zero.
REMARK CODES	The Code List Qualifier Code and the Health Care Remark Code (Remittance Advice Remark Codes). The Code List Qualifier Code is a code identifying a specific industry code list. Values are: HE = Claim Payment Remark Code RX = National Council for Prescription Drug Programs Reject/Payment Codes. The Health Care Remark Codes (Remittance Advice Remark Codes) are codes used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.
CATEGORY TOTALS	Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, etc.) has separate totals for number of claims, billed amount, allowed amount, and paid amount.

HCY SCREENINGS

Effective with date of service October 16, 2003, the Health Children and Youth (HCY) screening code W0025 is no longer a valid code. Developmental/Mental Health Partial Screens are billable by a psychologist, LCSW or LPC with the new codes. These screening codes do not use the AH, AJ, UD, or U8 modifiers. Instead the codes must have a 59 modifier and if the child is referred on for further care a UC modifier. The diagnosis code V202 is the only valid diagnosis code for a partial HCY screening.

Proc. Code for Svc. Dates prior to 10-16-03	Modifier	Proc. Code for Svc. Dates after 10-16-03	New Modifier 1	New Modifier 2	Fee
W0025	XE	99429	59		\$15.00
W0025	XF	99429	59	UC	\$15.00

****Modifier "UC" must be used if child was referred for further care as a result of the screening. Modifier "UC" must always appear as the last modifier.***

MODIFIERS

Effective for dates of service November 01, 2003 and after claims must be submitted using the appropriate modifier(s). The specialty modifier is always required.

AH – Psychologist

AJ – Licensed Clinical Social Worker

UD – Licensed Professional Counselor

U8 – in home (12) or private school (99)

| (The U8 modifier is not appropriate when billing 90853 regardless of POS)

FREQUENTLY USED PLACE OF SERVICE CODES

04 – Homeless Shelter	11 – office
12 – Home	14 – Group Home
21 – Inpatient Hospital	22 – Outpatient Hospital
33 – Custodial Care Facility	50 – FQHC
51 – Inpatient Psychiatric Facility	56 – Psychiatric Residential Treatment
61 – Comprehensive Inpatient Rehabilitation Facility	
72 – Rural Health Clinic	99 – Private School

Refer to the Special HIPAA bulletin dated September 30, 2003 or the CMS website for complete list of POS codes and additional description information.

TIME-BASED SERVICE LIMITATIONS

A therapy procedure code representing a measure of time as defined in the CPT is covered for one (1) unit per day. The provider must choose the appropriate time measure to represent the service furnished.

A unit of service, which represents 20-30 minutes, must include at least 20 minutes face-to-face with the client. When less than 30 minutes is spent face-to-face with the client, the remainder of the time must be directed towards the benefit of the client including, but not limited to, report writing, note summary, reviewing treatment plan, etc.

Appointments must be scheduled in 30-minute increments to bill Medicaid for one (1) half-hour session of service. Appointments scheduled less than 30 minutes are deemed to be less than 20 minutes face-to-face and are not covered.

A unit of service, which represents 45-50 minutes, must include at least 45 minutes face-to-face with the client. When less than 50 minutes is spent face-to-face with the client, the remainder of the time must be directed towards the benefit of the client including, but not limited to, report writing, note summary, reviewing treatment plan, etc.

Appointments must be scheduled in 50-minute increments to bill Medicaid for a 45-50 minute session of service. Appointments scheduled less than 50 minutes are deemed to be less than 45 minutes face-to-face and are not covered.

Currently, the CPT definition for assessment, family therapy with or without the patient present, and group therapy is not time limited; and DMS defines a unit of service as a half hour. (These therapies must be provided in full 30-minute units.)

Testing and crisis intervention are defined in the CPT as hour services and a full 60 minutes of services must be provided.

Documentation must be made at the time services are delivered.

Travel time is not reimbursable and must not be included as part of the scheduled appointment time.

Providers may not bill a combination of any psychotherapy codes that have the same description, except for time, on the same date of service. For example a half hour of 90804 and 45-50 minutes of 90806 is not covered on the same date of service.

Providers may not bill a combination of time measured psychotherapy codes with a code including a medical component. For example 90804 and 90805 are not covered on the same date of service.

Certain services include a medical component and are not billable by a psychologist, LCSW, or LPC. These codes are 90805, 90807, 90811, 90813, 90817, 90819, 90824, 90827, 90862, 90865, 90870, and 90871.

Certain services are not covered when provided by an LCSW or LPC and may not be billed for an adult or child in any setting. These codes are 96100, 96105, 96111, and 96115.

Psychology/counseling services are not billable by a psychiatrist, PCNS, psychologist, LCSW or LPC in a nursing home setting. **Psychiatrists and PCNS may provide pharmacologic management, procedure code 90862 in the nursing home setting.**

FAMILY THERAPY

Family therapy is defined as the treatment of family members as a family unit, rather than an individual patient. When family therapy without the patient present (90846) or family therapy with the patient present (90847) is provided, the session is billed as one service (one family unit), regardless of the number of individuals present at the session. Provider may not bill for family therapy for each family member. This will be monitored by the Program Integrity Unit. Treatment of family members (adults) is not covered when provided by an LCSW or LPC. Family therapy furnished by an LCSW or LPC must be directed exclusively to the treatment of the child. Parental issues may not be billed.

A psychiatrist, PCNS, and psychologist may bill for services provided to an adult. When a family consists of a Medicaid/MC+ eligible adult and child(ren) and the therapy is not directed at one specific child, services may be directed to the adult for effective treatment of the family unit to address the adult's issues and impact on the family. If the adult is not eligible and the family therapy is directed to the adult and not the child, the service may not be billed using the child's DCN.

If there is more than one eligible child and no child is exclusively identified as the primary recipient of treatment, then the oldest child's DCN must be used for billing purposes.

A family may be biological, foster, adoptive or other family unit. A family is not a group and **providers may not submit a claim for each eligible person attending the same family therapy session.**

GROUP THERAPY

Group therapy must consist of 3 but no more than 10 individuals who are not members of the same family.

Group therapy may not be billed on the same date of service as family therapy (90846 or 90847) unless the client is inpatient, in a residential treatment facility, or custodial care facility. Group therapy in a group home is billed with POS 14. Group therapy in a residential/custodial facility is billed with POS 33. Group therapy in a shelter type setting is billed with POS 04.

PLACE OF SERVICE CODE

Effective for dates of service July 01, 2005 and after, the only valid setting for using place of service code 99 is a private school.

Place of service 99 cannot be used for therapy provided in a public setting. A public setting includes but is not limited to: a parked or moving vehicle, library, park, shopping center, restaurants, etc. Providers must use the appropriate place of service code for the setting in which services are rendered. If there is no place of service code that matches the setting, services may not be billed to Medicaid. Although there is a place of service 15 for mobile unit, Medicaid does not cover services provided in this setting.

SCHOOL BASED SERVICES

When services are provided on public school grounds, the provider must enroll with a pay-to of the school district in which the school is located. A Missouri Medicaid provider number is required for each school district where services are being provided. The only appropriate place of service for a public school setting is 03 and must be used.

DIAGNOSIS CODES

The diagnosis code must be a valid ICD-9 diagnosis code and must be mental health related. This does not include mental retardation. The only valid code ranges for the psychology/counseling program are 290-316, V11-V118, V154-V1542, V17-V170, V40-V401, V61-V619, V624, V628-V6289, V673, V710-V7102, and V79-V791. An appropriate 4th or 5th digit may be required for the diagnosis code to be valid.

DOCUMENTATION REQUIREMENTS

DIAGNOSTIC ASSESSMENT

A Diagnostic Assessment CSR 70-98.015 from a Medicaid enrolled provider must be documented in the client's medical record. This assessment will assist in ensuring an appropriate level of care, identifying necessary services, developing a treatment plan and documenting the following:

- Statement of needs, goals, and treatment expectations from the individual requesting services; the family's perceptions when appropriate and available
- Presenting problem and referral source
- History of previous psychiatric and/or substance abuse treatment including number and type of admissions
- Current medications; medication allergies/adverse reactions
- Recent alcohol/drug use for at least the past 30 days; a substance abuse history including duration, patterns, and consequence of use
- Current psychiatric symptoms
- Family, social, legal, and vocational/educational status and functioning. Historical data is also required unless short-term crisis intervention or detoxification are the only services being provided
- Current use of resources and services from other agencies
- Personal and social resources and strengths, including availability of family, peer, and other natural supports
- Multi-axis diagnosis or diagnostic impression according to the current edition of the DSM or International Classification of Diseases, Ninth Revision (ICD-9). The ICD-9 code is required on the treatment plan for billing purposes.

PLAN OF TREATMENT

A Plan of Treatment is required documentation as part of the client's medical record. A treatment plan must be developed based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the client's situation and reflects the need for psychology/counseling services. The Treatment Plan must be individualized to reflect the unique needs and goals of the client. The treatment plan must include but is not limited to the following:

- Measurable goals and outcomes
- How each goal/outcome will be accomplished
 - Services, supports, staff member responsible,
 - Actions required of the recipient, family, peers, etc.
- Involvement of family, when indicated
- Identification of and plan for coordinating with other agencies
- Referrals to other organizations for other needed services
- Identification of medications
- Projected time frame for completion of each goal/outcome
- Estimated completion/discharge date

TREATMENT UPDATE:

The treatment plan must be reviewed on a periodic basis to evaluate progress towards goals/outcomes and to update the plan. Each client will participate in the review of his/her treatment plan. The frequency of plan reviews is based on the level of care or other program rules. A crisis or significant event may require additional review and the treatment plan must be updated and changed as indicated. Each update must include the therapist's assessment of current symptoms and behaviors related to diagnosis, progress towards goals, justification of changed or new diagnosis, and response to other concurrent treatments such as family or group therapy and medications. Plans for continuing treatment and/or termination from therapy and aftercare must be expressed in each treatment plan update.

PROGRESS NOTES

Progress Notes must be written in narrative form, fully describe each session, and be kept in the patient's medical record for each date of service for which a claim is filed. A check-off list or pre-established form is not acceptable as sole documentation.

Progress notes for psychology/counseling services must specify:

- First and last name of client
- Specific service rendered
- Date
- Actual clock begin and end times (1:00 p.m. to 2:00 p.m.)
- Name of person who provided the service
- Setting
- Recipient's report of recent symptoms and behaviors related to diagnosis and treatment plan goals
- Therapist's intervention for the visit and recipient's response
- Recipient's progress towards goals in treatment plan
- Family therapy - must identify each member of the family, first and last name, included in the session and
 - Description of immediate issue addressed
 - Identification of underlying roles, conflicts or patterns
 - Description of therapist intervention
- Group therapy - must identify the number of group members present and
 - Description of immediate issue addressed
 - Identification of underlying roles, conflicts or patterns
 - Description of therapist intervention and progress towards goals

Note: If **Individual Interactive Therapy** is provided, the documentation must include the need for this service and the type of equipment, devices, or other mechanism of equipment used.

If the service is for a child in the legal custody of the Children's Division (CD), a copy of the Treatment Plan must be provided to the CD.

These documentation requirements do not replace or negate documentation/reports required by CSD for individuals in their care and custody. Providers are expected to comply with policies and procedures established by CD.

AFTERCARE PLAN

When care is completed, the aftercare plan must include, but is not limited to, the following:

- Dates (care) begin and end
- Frequency and duration of visits
- Target symptoms/behaviors addressed
- Interventions
- Progress achieved towards goals
- Final diagnosis
- Final recommendations including further services, providers, and activities to promote further recovery

For all medically necessary covered services, the stipulated documentation is an essential and integral part of the service. No service will be considered performed if documentation requirements are not met, and no reimbursement will be made.

Only the enrolled Missouri Medicaid provider can provide psychology/counseling services and be reimbursed. Missouri Medicaid does not cover services provided by someone other than the enrolled provider.

Services provided by an individual under the direction or supervision of the enrolled provider are not covered.

Medicaid providers must retain for six (6) years from the date of service, fiscal and medical records that coincide with and fully document services billed to Medicaid and must furnish or make records available for inspection or audit by the Department of Social Services or its representative upon request.

PROCEDURE CODES FOR LCSW AND LPC

The procedure codes listed below are the only counseling codes billable by an LCSW or LPC. The appropriate AJ or UD must be used for all codes.

Procedure Code	Modifier	Maximum Allowed	Maximum Quantity	Description
90801		\$24.00	6	Assessment
90801	U8	\$29.00	6	Assessment-home/private school (PS)
90802		\$24.00	2	Assessment-interactive (intac)
90802	U8	\$29.00	2	Assessment-interactive-home/PS
90804		\$24.00	1	Individual 20-30 mins
90804	U8	\$29.00	1	Individual 20-30 mins- home/PS
90806		\$48.00	1	Individual 45-50 mins
90806	U8	\$58.00	1	Individual 45-50 mins- home/PS
90810		\$24.00	1	Intac Indiv 20-30 mins
90810	U8	\$29.00	1	Intac Indiv 20-30 mins- home/PS
90812		\$48.00	1	Intac Indiv 45-50 mins
90812	U8	\$58.00	1	Intac Indiv 45-50 mins-home/PS
90816		\$24.00	1	Indiv hosp 20-30 mins
90818		\$48.00	1	Indiv hosp 45-50 mins
90823		\$24.00	1	Intac Indiv Hosp 20-30 mins
90826		\$48.00	1	Intac Indiv Hosp 45-50 mins
90846		\$24.00	2	Family w/o Patient
90846	U8	\$29.00	2	Family w/o Patient-home/PS
90847		\$24.00	2	Family w/ Patient
90847	U8	\$29.00	2	Family w/ Patient-home/PS
90853		\$10.00	3	Group Therapy
S9484		\$48.00	6	Crisis Intervention, hour
S9484	U8	\$53.00	6	Crisis Intervention, hour-home/PS

PROCEDURE CODES FOR PSYCHOLOGISTS

The procedure codes listed below are the only counseling codes billable by a psychologist. The AH modifier must be used on all codes.

Procedure Code	Modifier	Maximum Allowed	Maximum Quantity	Description
90801		\$30.00	6	Assessment
90801	U8	\$35.00	6	Assessment-home/private school PS
90802		\$30.00	2	Assessment-interactive (intac)
90802	U8	\$35.00	2	Assessment-interactive-home/PS
90804		\$30.00	1	Individual 20-30 mins
90804	U8	\$35.00	1	Individual 20-30 mins- home/PS
90806		\$60.00	1	Individual 45-50 mins
90806	U8	\$70.00	1	Individual 45-50 mins- home/PS
90810		\$30.00	1	Intac Indiv 20-30 mins
90810	U8	\$35.00	1	Intac Indiv 20-30 mins- home/PS
90812		\$60.00	1	Intac Indiv 45-50 mins
90812	U8	\$70.00	1	Intac Indiv 45-50 mins-home/PS
90816		\$30.00	1	Indiv hosp 20-30 mins
90818		\$60.00	1	Indiv hosp 45-50 mins
90823		\$30.00	1	Intac Indiv Hosp 20-30 mins
90826		\$60.00	1	Intac Indiv Hosp 45-50 mins
90846		\$30.00	2	Family w/o Patient
90846	U8	\$35.00	2	Family w/o Patient-home/PS
90847		\$30.00	2	Family w/ Patient
90847	U8	\$35.00	2	Family w/ Patient-home/PS
90853		\$12.50	3	Group Therapy
90880		\$8.00	1	Hypnotherapy
90885		\$24.00	1	Psych eval of records
96100		\$60.00	4	Testing
96100	U8	\$60.00	4	Testing- home/PS
96105		\$35.00	1	Assess of aphasia
96111		\$35.00	1	Developmental testing, extended
96115		\$35.00	1	Neurobehavior status exam
S9484		\$60.00	6	Crisis Intervention, hour
S9484	U8	\$65.00	6	Crisis Intervention, hour- home/PS

PSYCHIATRISTS, PSYCHIATRIC CLINICAL NURSES, FQHC, AND RHC

Procedure Code	Modifier	Medicaid Maximum Allowed	Maximum Quantity	Description
90801		30.00	6	Psy dx interview
90801	U8	35.00	6	Psy dx interview, home/private school PS
90802		30.00	2	Intac psy dx interview
90802	U8	35.00	2	Intac psy dx interview, home/PS
90804		30.00	1	Psy tx, office, 20-30 min
90804	U8	35.00	1	Psy tx, 20-30 min, home/PS
90805		35.00	1	Psy tx, off, 20-30 min w/e&m
90805	U8	40.00	1	Psy tx, 20-30 min w/e&m, home/PS
90806		60.00	1	Psy tx, off, 45-50 min
90806	U8	70.00	1	Psy tx, 45-50 min, home/PS
90807		65.00	1	Psy tx, off, 45-50 min w/e&m
90807	U8	75.00	1	Psy tx, 45-50 min w/e&m home/PS
90810		30.00	1	Intac psy tx, off, 20-30 min
90810	U8	35.00	1	Intac psy tx, 20-30 min, home/PS
90811		35.00	1	Intac psy tx, 20-30 w/e&m
90811	U8	40.00	1	Intac psy tx, 20-30, w/e&m, home/PS
90812		60.00	1	Intac psy tx, off, 45-50 min
90812	U8	70.00	1	Intac psy tx, 45-50 min home/PS
90813		65.00	1	Intac psy tx, 45-50 min w/e&m
90813	U8	75.00	1	Intac psy tx, 45-50 min w/e&m, home/PS
90816		30.00	1	Psy tx, hosp, 20-30 min
90817		35.00	1	Psy tx, hosp, 20-30 min w/e&m
90818		60.00	1	Psy tx, hosp, 45-50 min
90819		65.00	1	Psy tx, hosp, 45-50 min w/e&m
90823		30.00	1	Intac psy tx, hosp, 20-30 min
90824		35.00	1	Intac psy tx, hosp 20-30 w/e&m
90826		60.00	1	Intac psy tx, hosp, 45-50 min
90827		65.00	1	Intac psy tx, hosp, 45-50 w/e&m
90846		30.00	2	Family psy tx w/o patient
90846	U8	35.00	2	Family psy tx w/o patient, home/PS
90847		30.00	2	Family psy tx w/patient
90847	U8	35.00	2	Family psy tx w/patient, home/PS
90853		12.50	3	Group psychotherapy
90862		12.50	1	Medication management
90865		25.00	1	Narcosynthesis
90870		30.00	1	Electroconvulsive therapy
90871		30.00	3	Electroconvulsive therapy

Procedure Code	Modifier	Medicaid Maximum Allowed	Maximum Quantity	Description
90880		8.00	1	Hypnotherapy
90885		24.00	1	Psy evaluation of records
96100		60.00	4	Psychological testing
96105		35.00	1	Assessment of aphasia
96111		35.00	1	Developmental test, extend
96115		35.00	1	Neurobehavior status exam
S9484		60.00	6	Crisis intervention, per hour
S9484	U8	65.00	6	Crisis intervention, per hour home/PS

The U8 Modifier is the only appropriate modifier and must be used when submitting claims for place of service 12 (home) or 99 (private school – PS) as indicated.

PRIOR AUTHORIZATION

ADULTS

Psychologist, Psychiatrist, PCNS, RHC, FQHC

The Psychology/Counseling bulletin, dated October 01, 2004, outlined a new Prior Authorization (PA) process. Prior Authorization approved the medical necessity of the requested service and does not guarantee payment. The recipient must meet eligibility requirements and the provider must be enrolled and eligible to bill the services.

Effective for dates of service November 01, 2004, and after, many psychological services provided to adults (21 years of age or older) must be prior authorized when performed by a psychiatrist, psychologist, psychiatric clinical nurse specialist (PCNS), rural health clinic (RHC), or federally qualified health center (FQHC).

Effective for dates of service May 01, 2005 and after Interactive therapy for adults is not allowed under the four (4) hours of non-prior authorized services. All Interactive therapy must be prior authorized.

Adult services provided by LCSWs and LPCs are not covered by Missouri Medicaid, except RHC/FQHC.

Family Therapy Without the Patient Present requires prior authorization for adults regardless of age.

CHILDREN

In subsequent phases, the Division of Medical Services (DMS) will implement new prior authorization measures for children for most psychology/counseling services.

Effective for dates of service May 01, 2005 and after, the PA process was implemented for children, 0 through 20 years of age, who are not in state custody or residing in a residential treatment facility.

The PA process for children in state custody or residing in a residential treatment facility will be implemented at a later date. Providers will be notified via bulletins regarding the effective dates for these groups of children.

The requirement for prior authorization will include services provided by a psychiatrist, psychologist, PCNS, provisionally licensed clinical social worker

(PLCSW), licensed clinical social worker (LCSW), provisionally licensed professional counselor (PLPC), licensed professional counselor (LPC), RHC, or FQHC.

ADULTS AND CHILDREN

Codes Requiring PA – Psychologist, Psychiatrist, PCNS, RHC, and FQHC

Assessment – Insight 90801 (30 minute session)

Maximum of 6 units per rolling year

Assessment – Interactive 90802 (30 minute session)

Maximum of 2 units per rolling year

Individual Therapy 90804 / 90810 (20 – 30 minute session)

Individual Therapy 90806 / 90812 (45 – 50 minute session)

Maximum of 1 unit, either 30 minute or 45-50 minute session per day;

Maximum of 5 units, any combination of 30 minute or 45-50 minute sessions per month

Family Therapy 90846 / 90847 (30 minute session)

Maximum of 2 units per procedure per day;

Maximum of 10 units per month

Group Therapy 90853 (30 minute session)

Maximum of 3 units per day;

Maximum of 15 units per month

Testing 96100 (60 minute session)

Maximum of 4 units per rolling year

Hypnotherapy 90880 (no time frame noted)

Aphasia Assessment 96105 (60 minute session)

Developmental testing 96111 (60 minute session)

Neurobehavioral testing 96115 (60 minute session)

Effective for dates of service 07-01-05 and after, 90899 unlisted psychiatric services or procedures will no longer be a payable code.

The AH modifier must be included when billing claims for psychologists.

Codes Not Requiring PA – Psychologist, Psychiatrist, PCNS, RHC and FQHC

Individual Inpatient 90816 / 90823 (20 – 30 minute session)

Individual Inpatient 90818 / 90826 (45 – 50 minute session)

Evaluation Inpatient Records 90885 (no time frame noted)

Evaluation and Management codes

Crisis Intervention S9484 (60 minute session)

Crisis Intervention

The definition of crisis intervention is: “the situation must be of significant severity to pose a threat to the patient’s well being or is a danger to self or others”. Crisis intervention services cannot be scheduled nor can they be prior authorized.

Regardless of prior authorization, providers are required to adhere to the maximum daily and monthly unit limitations and all other program restrictions. Units over the daily and monthly limits will no longer be reimbursed.

CHILDREN

Codes Requiring PA – PLCSW, LCSW, PLPC, LPC

Assessment – Insight 90801 (30 minute session)
Maximum of 6 units per rolling year

Assessment – Interactive 90802 (30 minute session)
Maximum of 2 units per rolling year

Individual Therapy 90804 / 90810 (20 – 30 minute session)
Individual Therapy 90806 / 90812 (45 – 50 minute session)
Maximum of 1 unit, either 30 minute or 45-50 minute session per day;
Maximum of 5 units, any combination of 30 minute or 45-50 minute
sessions per month

Family Therapy 90846 / 90847 (30 minute session)
Maximum of 2 units per procedure per day;
Maximum of 10 units per month

Group Therapy 90853 (30 minute session)
Maximum of 3 units per day;
Maximum of 15 units per month

Codes Not Requiring PA – PLCSW, LCSW, PLPC, LPC

Individual Inpatient 90816 / 90823 (20 – 30 minute session)

Individual Inpatient 90818 / 90826 (45 – 50 minute session)

Crisis Intervention S9484 (60 minute session)

Crisis Intervention

The definition of crisis intervention is: “the situation must be of significant severity to pose a threat to the patient’s well being or is a danger to self or others”. Crisis intervention services cannot be scheduled nor can they be prior authorized.

Regardless of prior authorization, providers are required to adhere to the maximum daily and monthly unit limitations and all other program restrictions. Units over the daily and monthly limits will no longer be reimbursed.

GENERAL INFORMATION - GUIDELINES - Adults

Independent LCSWs and LPCs may not see adults and should not request prior authorization for psychology/counseling services for clients 21 year of age or older.

LCSWs and LPCs who are members of an FQHC or RHC may provide adult services as part of the clinic. These services will require prior authorization but the request is made using the facility provider number.

Psychological services will be covered if they are determined medically necessary when using the DSM IV-TR diagnostic criteria. However, the diagnosis code on a submitted claim must be the appropriate ICD-9 code.

The first four (4) hours of psychotherapy services for adults do not require prior authorization. During this time the provider may see the recipient to determine if further visits are medically necessary. These four (4) hours may consist of testing, assessment, individual therapy, group therapy or family therapy with the patient present. The first four (4) hours is per recipient, per provider. Four (4) non-Prior Authorizations do not apply if providing family therapy without the patient present or individual interactive therapy, which requires Prior Authorization of all hours.

After the initial 4 hours, for services that are non-Prior Authorization is determined that ongoing services are medically necessary, prior authorization must be obtained. This prior authorization must be requested before rendering additional services. In order not to interrupt services it would be best to request authorization before all 4 hours are used. The first PA request will be the initial PA and any services requested after this will be considered continued treatment.

Approval will be based on the DSM IV-TR diagnosis code. Up to ten (10) hours of individual therapy will be authorized initially for a diagnosis of Adjustment Disorder, V-codes, or NOS codes. Up to twenty (20) hours will be authorized initially for all other covered diagnosis codes. Family and group therapy will be approved for up to 10 hours for all covered mental health diagnoses.

The first request for PA can include individual therapy, testing, assessment, group family therapy. Testing, assessment, and group and family therapy must be identified separately.

If testing is requested, the allowed number of hours will depend on the number of hours approved based on the diagnosis code. Two (2) hours may be used for testing when approved for 10 hours and four (4) hours may be used for testing when approved for 20 hours. This is per recipient, per provider, per rolling year. Unit limitations apply for services whether used during the initial four (4) hours or as part of the prior authorized hours.

To request the initial 10 or 20 hours for most psychological services, you or a staff member may call (866) 771-3350. You should complete the Psychological Services Request for Prior Authorization form, as the information on this form will be required to complete the initial request for services. Telephoned requests will receive an approval or denial at the time of the call. If additional information is needed, the caller will be instructed to fax or mail the PA form and required documentation. This PA request will not be approved during the phone call.

To request continuing services beyond the initial authorization, the Psychological Services Request for Prior Authorization form must be completed and submitted along with the current Treatment Plan, current diagnostic assessment and copies of the last three (3) Progress Notes. This documentation may be faxed to (573) 635-6516 or mailed to Division of Medical Services, PO Box 4800, Jefferson City, MO 65102. Before requesting additional hours, 75% of the current authorized hours must be used.

All family therapy without the patient present and individual interactive therapy will require the PA Form, current diagnostic assessment, current Treatment Plan, and the last three (3) Progress Notes be mailed or faxed.

Providers will not receive a disposition letter when services are authorized or denied via a phone call. An authorization number will be provided. Services that require submission of the PA form and attachments will receive a disposition letter after review. When PA requests are denied partially or in full, the client will receive a letter outlining the reason for denial and their appeal rights. **Do not give clients the provider Prior Authorization Request telephone number or fax number. Their contact information will be listed in their denial letter.**

Only one (1) individual therapy PA and one (1) group or family PA per client will be issued at any time. If the client is changing providers, the provider listed on the current PA must end that PA before the new provider can be issued a PA. If the current provider refuses to close the PA, the new provider must submit a signed release from the client, requesting a change in provider, in order to close the current PA. The signed release must include the recipient's DCN, type of therapy to be closed and the name of the therapist whose authorization is to be closed.

If a provider needs to change a PA, the provider may call or fax in the information to request a change. The client's name, DCN, type of therapy, what the current PA says, and the requested change must be indicated.

A client may have an open PA with one provider for individual therapy and a second PA open with the same or different provider for family or group therapy.

Most prior authorizations will be requested using the individual (49) provider number. Private non-FQHC clinics/groups with a provider number beginning 50 must request prior authorization using the individual (49) provider number. However, authorization for services being rendered by a member of an FQHC must be requested by using the FQHC (50) provider number. Services being rendered by a member of an RHC must request prior authorization using the RHC (59) provider number.

Do not request overlapping dates from a previous PA; overlapping dates will cause the new PA request to deny.

Prior authorization is still required even when there is coverage through a third party insurance (i.e. Blue Cross/Blue Shield; Prudential). Medicare is not considered third party insurance; however, if there is no PA and Medicare does not cover the service, Medicaid cannot pay.

Prior authorization is required for clients residing in a nursing home but the psychology/counseling services may not be provided at the nursing home.

Psychiatrists and PCNS may provide pharmacologic management, procedure code 90862, in the nursing home setting.

Providers may only bill for services they personally provide. Medicaid does not cover services provided by someone other than the enrolled provider. Services provided by an individual under the direction or supervision of an enrolled provider are not covered.

Prior Authorization Exceptions

In-patient hospital stays

Crisis intervention

Procedure codes with a medical evaluation and management service component

Pharmacologic management

Narcosynthesis

Electroconvulsive Therapy

Services covered and reimbursed by Medicare; if Medicare denies services a PA would be required for Medicaid to reimburse. If you are unsure that Medicare will pay, you must request a PA prior to rendering services, as Medicaid will not backdate a PA.

GENERAL INFORMATION - GUIDELINES – Children

The Division of Medical Services (DMS) has made PA requirement changes for psychological services for children and will be implementing additional changes for children. Previous policy, new policy changes, and planned changes are outlined below.

Effective November 01, 2004, individual therapy, family therapy with the patient present, and group therapy required prior authorization for children under the age of three (3) when performed by a psychiatrist, psychologist, and psychiatric clinical nurse specialist.

Effective November 01, 2004, family therapy without the patient present requires prior authorization when provided by a psychiatrist, psychologist, psychiatric clinical nurse specialist, regardless of the **age of the client**.

Family therapy without the patient present, regardless of the age of the child, has always required prior authorization when provided by an LCSW, LPC, PLCSW, PLPC, RHC, or FQHC. This policy remains in effect.

Prior authorization has always been required for individual therapy, family therapy with the patient present, and group therapy for children under the age of three (3) when services are provided by an LCSW, LPC, PLCSW, PLPC, RHC or FQHC.

When requesting prior authorization psychological services will be covered if they are determined medically necessary when using the DSM IV-TR diagnostic criteria. However, the diagnosis code on a submitted claim must be the appropriate ICD-9 code.

Testing services are not covered when provided by a PLCSW, LCSW, PLPC, or LPC regardless of the age of the client.

All services for children under the age of three (3) and family therapy without the patient present require the PA Form, current diagnostic assessment, current Treatment Plan, and the last three (3) Progress Notes be mailed or faxed. **If requesting Prior Authorization for assessment or testing for a child under the age of 3, providers must submit clinical justification for providing services.**

An authorization number will be provided when Prior Authorization is requested and approved on a phone call. Services that require submission of the PA Form and attachments will receive a disposition letter after review. When PA requests are denied partially or in full, the client will receive a letter outlining the reason for denial and their appeal rights. **Do not give clients the provider Prior**

Authorization Request telephone number or fax number. Their contact information will be listed in their denial letter.

If the client is changing providers, the provider listed on the current PA must end that PA before the new provider can be issued a PA. If the current provider refuses to close the PA, the new provider must submit a signed release from the client, requesting a change in provider, in order to close the current PA. The signed release must include the client's DCN, the type of therapy to be closed, and the name of the therapist whose authorization is to be closed.

If a provider needs to change a PA, the provider may call or fax in the information to request a change. The client's name, DCN, type of therapy, what the current PA says, and the requested change must be indicated.

Most prior authorizations will be requested using the individual (49) provider number. Private non-FQHC clinics/groups with a provider number beginning 50 must request prior authorization using the individual (49) provider number. Authorization for services being rendered by a member of an FQHC (Federally Qualified Health Care) must be requested by using the FQHC (50) provider number and the performing provider name. Services being rendered by a member of an RHC (Rural Health Clinic) must request prior authorization using the RHC (59) provider number.

Do not request overlapping dates from a previous PA; overlapping dates will cause the new PA request to deny.

Prior authorization is still required even when there is coverage through a third-party insurance (i.e. Blue Cross/Blue Shield; Prudential). Medicare is not considered a third-party insurance; however, if there is no PA and Medicare does not cover the service, Medicaid cannot pay.

Prior authorization has always been required for individual therapy, family therapy with the patient present, and group therapy for children under the age of three (3) when services are provided by an LCSW, LPC, PLCSW, PLPC, RHC or FQHC. This policy remains in effect.

Prior authorization is required for clients residing in a nursing home but the psychology/counseling services may not be provided at the nursing home. **Psychiatrists and PCNS may provide pharmacologic management, 90862, in the nursing home setting.**

Providers may only bill for services they personally provide. Medicaid does not cover services provided by someone other than the enrolled provider. Services provided by an individual under the direction or supervision of an enrolled provider are not covered.

Prior authorization is required for psychological services provided on public or private school district grounds when billing to Medicaid. The provider must have a separate Medicaid provider number with a pay-to of the public school district.

Prior Authorization Exceptions

Inpatient hospital stays

Crisis intervention

Procedure codes with a medical evaluation and management service component

Pharmacologic management

Narcosynthesis

Electroconvulsive Therapy

Services covered and reimbursed by Medicare; if Medicare denies services a PA would be required for Medicaid to reimburse. If you are unsure that Medicare will pay, you must request a PA prior to rendering services, as Medicaid will not backdate a PA.

New Prior Authorization Policy for Children 0 through 20

Effective May 01, 2005, the Division of Medical Services implemented a prior authorization process for all children birth (0) through 20 who are not in state custody or residing in a residential treatment facility. Prior authorization requirements for children in state custody or in a residential facility will be implemented at a later date.

The PA process includes services provided by a psychiatrist, psychologist, PCNS, PLCSW, LCSW, PLPC, LPC, RHC, and FQHC.

The first four (4) hours of psychological services for most children and services do not require prior authorization. During this time the provider may see the recipient to determine if further visits are medically necessary. These four (4) hours may consist of testing, assessment, individual therapy, group therapy or family therapy. The first four (4) hours is per recipient, per provider. The first four (4) non-Prior Authorization hours do not apply if providing services to children under the age of 3, Interactive Therapy, or family therapy without the patient present.

After the initial 4 hours, interactive therapy which requires Prior Authorization of all hours, when it is determined that ongoing services are medically necessary, prior authorization must be obtained. This prior authorization must be requested before rendering additional services. In order not to interrupt services it would be best to request authorization before all 4 hours are used. The first PA request will be the initial authorization and any services requested after this will be considered continued treatment. Except for those situations indicated above the preferred method of therapy may be requested by calling the Psychological Services Prior Authorization telephone number.

You or a staff member may place the call but the Psychological Services Request for Prior Authorization (PA) Form must be completed, as the information on this form will be required to complete the request for services. Telephoned requests will receive an approval or denial at the time of the call. If additional information is needed the caller will be instructed to fax or mail the PA form and required documentation. This PA request will not be approved during the phone call.

Prior authorization of psychology/counseling services for children is based on the age of the child and the type of therapy requested. Based on these limitations the first request for PA can include testing, assessment, individual, family, and group therapy.

If testing is requested the allowed number of hours will depend on the number of hours approved based on the diagnosis code. Two (2) hours may be used for testing when approved for 10 hours and 4 hours may be used for testing when approved for 20 hours. This is per recipient, per provider, per rolling year. Unit limitations apply for services whether used during the initial 4 hours or as part of the prior authorized hours. **If requesting prior authorization for assessment or testing for a child under the age of 3, providers must submit clinical justification for providing these services.**

To request continuing services after the initial authorization, the Psychological Services Request for Prior Authorization Form must be completed and submitted along with the current Treatment Plan, current diagnostic assessment and copies of the last three (3) Progress Notes. If the services being requested are court ordered, a copy of the court order must also be attached. Before requesting additional hours, 75% of the current authorized hours must be used.

Approval will be based on the DSM IV-TR diagnosis code. Up to ten (10) hours of individual therapy will be allowed for a diagnosis of Adjustment Disorder, V-codes, or NOS codes. Up to twenty (20) hours will be allowed for all other covered diagnosis codes. Family and group therapy will be approved for up to 10 hours for all covered mental health diagnoses. The authorized number of

hours is based on the primary diagnosis. Documentation must support the diagnosis code.

Providers will not receive a disposition letter when services are authorized or denied via a phone call. An authorization number will be provided. Services that require submission of the PA form and attachments will receive a disposition letter after review. When PA requests are denied partially or in full, the client will receive a letter outlining the reason for denial and their appeal rights. A Prior Authorization is not considered to be denied, if further documentation is required. **Do not give clients the provider Prior Authorization Request telephone number or fax number. Their contact information will be listed in their denial letter.**

Children are best treated within the environment in which they live. Clinical evidence suggests family intervention is superior to individual therapy in treating children with many psychological disorders. Therefore, treatment should support the child within the family whenever possible. Clinical evidence also suggests treatment must be based upon age and cognitive development of the child. Best Practice approaches should insure the coordination of care when multiple providers are involved with the same child/family.

Group therapy uses group dynamics and peer interactions to increase understanding and improve social skills.

Multiple therapies would be defined as a request for more than one therapy such as, individual and family, simultaneously within the same authorization period. The treatment plan must document the medical need for more than one therapy. There is no procedure code that specifies multiple therapies are being requested.

When requesting prior authorization for multiple therapies the Prior Authorization Request Form must be completed and faxed or mailed, along with the requested documentation, to DMS. The PA request needs to indicate all types of therapy being requested.

If a child's age changes during the prior authorization period, the prior authorization will continue as authorized. However, if the child turns 21 during the authorization period, the policy on age restriction for certain providers will apply. LPCs and LCSWs who are restricted to seeing children under the age of 21 will not be paid for services performed on or after the date the child reaches the age of 21 even if prior authorized.

Prior Authorization by Age Group

Psychology/counseling services for children under the age of 3, family therapy without the patient present and individual interactive therapy will not be allowed under the 4 hours of non-prior authorized service.

The preferred method of treatment is indicated first and if no documentation is required a telephone call may be made to request prior authorization. Services other than the preferred method and multiple therapies will require the PA Form and documentation be submitted via fax or mail.

Children Birth through 2

- Family therapy authorized initially with documentation and review
- Individual therapy will not be authorized
- Group therapy will not be authorized

Children 3 through 4

- Family therapy authorized initially without submitting documentation
- Individual therapy will not be authorized with the exception of interactive therapy with documentation and review. Your documentation must support interactive therapy is being provided
- Group therapy will not be authorized

Children 5 through 12

- Family therapy authorized initially without submitting documentation
- Group therapy authorized initially with documentation and review
- Individual therapy authorized initially with documentation and review
- Multiple therapies authorized initially with documentation and review

Children 13 through 17

- Individual therapy authorized initially without submitting documentation
- Family therapy authorized initially without submitting documentation
- Group therapy authorized initially with documentation and review
- Multiple therapies authorized initially with documentation and review

Children 18 through 20

- Individual therapy authorized initially without submitting documentation
- Family therapy authorized initially with documentation and review
- Group therapy authorized initially with documentation and review
- Multiple therapies authorized initially with documentation and review

Prior authorization requests may be made by calling: (866) 771-3350
OR submitting the PA form and required documentation to:

Mail: Division of Medical Services
PO Box 4800
Jefferson City, MO 65102
Fax: (573) 635-6516

Prior Authorization Tips

Children under the age of 3 always require a PA form and documentation. Testing and assessment will also require clinical justification.

Call for approval on an initial prior authorization when the service does not require documentation.

If requesting prior authorization for multiple therapies fax or mail the PA form along with all required documentation even though it may be the initial request. When a PA request has been faxed or mailed allow sufficient time for the request to be reviewed. Do not send duplicate requests; expect at least five (5) days for a reply. You may call any/either of the following numbers to check on the status of a PA request:

Provider Communications	(573) 751-2896
Provider Education	(573) 751-6683

When faxing PA requests only send one (1) at a time. Multiple requests on the same fax must be handled differently and result in additional delay in response. Don't fax questions to the Psych Help Desk-send questions using the ask DMS e-mail Internet address.

Review the documentation requirements to insure all aspects have been included and that appropriate documentation is being submitted with your prior authorization request.

Documentation is required for all services for children under 3, multiple therapies, continuing therapy, and non-preferred therapy. The required documentation is the current diagnostic assessment, current Treatment Plan, and the last 3 Progress Notes. If the psychological services being requested are court ordered, a copy of the court order must also be attached to the documentation.

If a child's age changes during the authorization period the prior authorization will continue as authorized. **BUT** if the child turns 21 during the authorization period the policy for age restrictions will still apply even when services are prior authorized.

Prior Authorization requests will not be backdated. Allow sufficient time for submission and review of the PA and documentation. This includes enough time to resubmit the PA and documentation in the event the first submission is denied.

Daily and monthly limitations still apply even though an authorization has been approved.

SECTION 6 ADJUSTMENTS

Providers who are paid incorrectly for a claim should use the paper *Individual Adjustment Request* form to request an adjustment. Providers may also submit an individual adjustment via the Infocrossing Internet service, www.emomed.com, by using the claim frequency type option 7 for a replacement or option 8 for a void. Adjustments may not be requested when the net difference in payment is less than \$4.00, or \$.25 for pharmacy, per claim. If the adjustment is due to an insurance payment, or involves Medicare, the \$4.00, or \$.25, minimum limitation does not apply.

In some instances, more than one change may be necessary on a claim. **All** the changes to the claim must be addressed on the same *Individual Adjustment Request* form. Specify all the necessary changes, listing each change separately. Field 15 of the form may be used to provide additional information. **Only one claim can be processed per *Individual Adjustment Request* form as each adjustment request can only address one particular claim.** A separate *Individual Adjustment Request* form must be completed for each claim that requires changes, even if the changes or errors are of a similar nature or are for the same patient.

When using the Infocrossing Internet service to replace a paid claim using claim frequency type option 7, each line of the original paid claim must be re-entered even though a certain line or lines may not require an adjustment. A reprocessed Internet claim will have an ICN that begins with a "49". Claim frequency type 8 is to be used only to void a previously paid claim and the payment is to be recouped. Claims voided through the Internet will appear on the next remittance advice with an ICN beginning with a "70".

Providers submitting adjustment requests for changes in type of service codes or procedure codes must provide documentation for these changes. A copy of the original claim and the medical or operative report must be attached, along with any other information pertaining to the claim.

If an adjustment filed on paper does not appear on a Remittance Advice within 90 days of submission, a copy of the original *Individual Adjustment Request* and any attachments should be resubmitted. Photocopies are acceptable. Mark this copy with the word "Tracer". Submitting another request without indicating it as a "tracer" can further delay processing. Adjustments for claim credits submitted via the Internet get a confirmation back the next day after submission to confirm the acceptance and indicate the status of the adjustment. If the Internal Control Number (ICN) on the credit adjustment is not valid, the confirmation file indicates such. If no confirmation is received, the provider should resubmit the claim credit.

See Section 4 of the Medicaid *Provider Manual* for timely filing requirements for adjustments and claim resubmissions. *Individual Adjustment Request* forms are to be submitted to the address shown on the form.

A sample Individual Adjustment Request is shown on the following page.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
MISSOURI MEDICAID
INDIVIDUAL ADJUSTMENT REQUEST

☐ UNDERPAYMENT ☒ OVERPAYMENT

TO FACILITATE PROCESSING, PLEASE ATTACH THE FOLLOWING:

1. Claim Copy
2. Remittance Advice Copy

FORWARD ORIGINAL TO:

ATTENTION: ADJUSTMENT UNIT
DIVISION OF MEDICAL SERVICES
P O BOX 6500
JEFFERSON CITY MO 65102

PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE:

3. INTERNAL CONTROL NUMBER 1604274009019	6. RECIPIENT NAME Nelson, Harry
4. RECIPIENT MEDICAID NUMBER 12345678	7. REMITTANCE ADVICE DATE 09/10/2004
5. PROVIDER LABEL Second Street Hospital #019999999 486 Second Street First City, MO 80000	8. R.A. PAGE NUMBER 25

REFER TO PROVIDER MANUAL ADJUSTMENT SECTION FOR INSTRUCTIONS

	SERVICE DATE	INFORMATION ON REMITTANCE ADVICE	CORRECTED INFORMATION
8. QTY/UNITS			
9. NDC/PROCEDURE CODE			
10. SERVICE DATE(S)			
11. BILLED AMOUNT			
12. PAID AMOUNT	08/04/2004	\$1,132.00	\$0.00
13. PATIENT SURPLUS			
14. OTHER RESOURCES (TPL) (IDENTIFY SOURCE)			

15. OTHER/REMARKS

Billed Medicaid in error before billing commercial insurance. Please take back payment.

HELPFUL HINTS FOR FILING AN ADJUSTMENT REQUEST FORM

1. Only one internal control number (claim) is allowed per request.
2. Only a *paid* claim can be adjusted. A denied claim *cannot* be adjusted (file a new claim with the corrected information on it.).
3. If you want Medicaid to recoup an entire payment, *do not* enter each line of the claim. Instead, complete the top of the form and line 12 only. Enter the date of service, the amount Medicaid paid, and a "0" in the corrected information field.
4. When a change to a claim is necessary, such as a service date or quantity, use the ICN of the claim that paid and file an adjustment request. Do not send a new claim as it will deny as a duplicate.
5. An ICN beginning with a "70" or "75" credits or recoups the original paid claim. An ICN beginning with a "50" or "55" repays the claim with the corrected information.
6. Use the 'Remarks' section of the form to explain the reason for the correction.

16. PROVIDER'S SIGNATURE	TITLE	DATE 10/13/2004
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SECTION 7

INSTRUCTIONS FOR COMPLETING THE MEDICARE PART B CROSSOVER STICKER

The Medicare Part B sticker should be legibly printed by hand or electronically. Complete the Medicare Part B/Medicaid-Title XIX sticker as follows and attach it to the Medicare Remittance Advice/Explanation of Medicare Benefits (RA/EOMB) so it does not cover the recipient's identifying information or claim payment information. Completed crossover claims should be mailed to:

Infocrossing Healthcare Services, Inc.
P.O. Box 5600
Jefferson City, MO 65102

MEDICARE PART B / MEDICAID - TITLE XIX	
Provider Name	
Provider Medicaid No.	
Recipient Name	
Recipient Medicaid No.	
Other Insurance Payment \$	
Name Other Insurance Co.	
Patient Account No.	
MEDICARE INFORMATION	
Beneficiary HIC No.	
Service Date: From	Through
Billed \$	Allowed \$
Paid \$	Paid Date
Deductible \$	Co-Ins \$
Blood Deductible \$	

<u>Field number & name</u>	<u>Instructions for completion</u>
1. Provider Name	Enter the provider's name as shown on the provider label.
2. Provider Medicaid Number	Enter the provider's nine-digit Medicaid number.
3. Recipient Name	Enter the patient's name exactly as shown on the ID card. (last name, first name).
4. Recipient Medicaid Number	Enter the recipient's eight-digit identification number as shown on the ID card.

<u>Field number & name</u>	<u>Instructions for completion</u>
5. Other Insurance Payment	Enter the amount paid by any other insurance or Medicare supplement.
6. Name Other Insurance Company	If an insurance amount is shown on line 5, enter name of insurance company. If the insurance plan denied payment, enter the plan name and attach a copy of the insurance denial to the claim.
7. Patient Account Number	For the provider's own information, a patient account number may be entered here.
8. Beneficiary HIC Number	Enter the patient's HIC Number as shown on the Medicare card.
9. & 10. Service Date: From and Through	Enter the date of service. If multiple dates of service are shown on the Medicare RA/EOMB for a single claim, enter the first chronological date of service in "From" field and the last chronological date of service in "Through" field.
11. Billed	Enter the total Medicare billed amount for the claim. Use the amount shown on the Medicare RA/EOMB.
12. Allowed	Enter the total Medicare allowed amount for the claim. Use the amount shown on the Medicare RA/EOMB.
13. Paid	Enter the total amount paid for the claim by Medicare.
14. Paid Date	Enter the date shown at the top of the Medicare RA/EOMB.
15.* Deductible	If any deductible was applied on this claim, enter the amount due in this field.
16.* Co-insurance	Enter the total amount of co-insurance due on this claim.
17. Blood Deductible	If there is a blood deductible due, enter that amount.

* Do not enter deductible and coinsurance amounts in the same field. They must each be listed in their own field.

MEDICARE BILLING TIPS

BILLING WHEN MEDICARE HAS A DIFFERENT PATIENT NAME THAN MEDICAID

On the paper crossover sticker, show the Medicaid name first with the Medicare name in parenthesis behind it, e.g. Smith, Roberta (Bobbi) or Jones (Masters), Gerald.

CLAIMS NOT CROSSING OVER ELECTRONICALLY

If none of a provider's Medicare claims are crossing over to Medicaid electronically, contact Medicaid to see if the provider has a Medicare number on file and that it is the correct one. Although Medicare advises that a claim was forwarded to Medicaid for processing, this does not guarantee that Medicaid received the claim information or was able to process it. If there is a problem with the claim or the recipient or provider files, the claim will not process. **A provider should wait 60 days from the date a claim was paid by Medicare before filing a crossover claim with Medicaid.** If a claim is submitted sooner, it is possible that the provider will receive a duplicate payment. If this occurs, the provider must submit an Individual Adjustment Request form to have Medicaid take back one of the payments.

TIMELY FILING

Claims initially filed with Medicare within Medicare timely filing requirements and that require separate filing of a crossover claim with Medicaid must meet the timely filing requirements by being submitted by the provider and received by the Medicaid agency within 12 months from the date of service or six months from the date on the provider's Medicare Explanation of Medicare Benefits (EOMB), whichever date is *later*. The counting of the six-month period begins with the date of adjudication of the Medicare payment and ends with the date of receipt.

BILLING FOR ELIGIBLE DAYS

A provider may attempt to bill only for eligible days on the Medicaid Part B claim form. In order for crossover claims to process correctly, a provider must bill all dates of service shown on the Medicare EOMB. The Medicaid claims system will catch those days' claims containing ineligible days and the claim will be prorated for the eligible days only.

ADJUSTMENTS

If Medicare adjusts a claim and Medicaid has paid the original crossover claim, then the original claim payment from Medicaid should be adjusted using an Individual Adjustment Request form with both Medicare EOMBs attached to the form.

SECTION 8 RESOURCE PUBLICATIONS FOR PROVIDERS

CURRENT PROCEDURE TERMINOLOGY (CPT)

Missouri Medicaid uses the latest version of the *Current Procedural Terminology* (CPT). All provider offices should obtain and refer to the CPT book to assure proper coding. Providers can order a CPT book from the American Medical Association.

Order Department
American Medical Association
P.O. Box 7046
Dover, DE 19903-7046
Telephone Number: 800/621-8335
Fax Orders: 312/464-5600

ICD-9-CM

The *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9) is the publication used for proper diagnostic coding. The diagnosis code is a required field on certain claim forms and the accuracy of the code that describes the patient's condition is important. The publication can be ordered from the following source.

Ingenix Publications
P.O. Box 27116
Salt Lake City, UT 84127-0116
800/464-3649
Fax Orders: 801/982-4033
www.IngenixOnline.com

HEALTH CARE PROCEDURE CODING SYSTEM (HCPCS)

Medicaid also uses the *Health Care Procedure Coding System (HCPCS), National Level II*. It is a listing of codes and descriptive terminology used for reporting the provision of supplies, materials, injections and certain services and procedures. The publication can be ordered from the following.

Practice Management Information Corporation
4727 Wilshire Blvd. Ste 300
Los Angeles, CA 90010
800/633-7467
<http://pmiconline.com>

SECTION 9

RECIPIENT LIABILITY

State Regulation 13CSR 70-4.030

If an enrolled Medicaid provider does not want to accept Missouri Medicaid as payment but instead wants the patient (recipient) to be responsible for the payment (be a private pay patient), there must be a written agreement between the patient and the provider in which the patient understands and agrees that Medicaid will not be billed for the service(s) and that the patient is fully responsible for the payment for the service(s). The written agreement must be date and service specific and signed and dated both by the patient and the provider. **The agreement must be done prior to the service(s) being rendered.** A copy of the agreement must be kept in the patient's medical record.

If there is no evidence of this written agreement, the provider cannot bill the patient and must submit a claim to Medicaid for reimbursement for the covered service(s).

If Medicaid denies payment for a service because all policies, rules and regulations of the Missouri Medicaid program were not followed (e.g., Prior Authorization, Second Surgical Opinion, etc.), the patient is not responsible and cannot be billed for the item or service.

All commercial insurance benefits must be obtained before Medicaid is billed.

MEDICAID RECIPIENT REIMBURSEMENT (MMR)

The Medicaid Recipient Reimbursement program (MMR) is devised to make payment to those recipients whose eligibility for Medicaid benefits has been denied and whose eligibility is subsequently established as a result of an agency hearing decision, a court decision based on an agency hearing decision, or any other legal agency decision rendered on or after January 1, 1986.

Recipients are reimbursed for the payments they made to providers for medical services received between the date of their denial and the date of their subsequent establishment of eligibility. The recipient is furnished with special forms to have completed by the provider(s) of service. If Medicaid recipients have any questions, they should call (800) 392-2161.

SECTION 10

FORMS

On the following pages are copies of various forms used by the Missouri Medicaid program.

Certain Medicaid programs, services, and supplies require the submission of a form before a claim can be processed for payment. Please note that several of the forms can be submitted electronically through the Infocrossing Internet service at www.emomed.com.

Acknowledgement of Receipt of Hysterectomy Information
Second Surgical Opinion
Sterilization Consent

If a form is submitted electronically, the provider **must** keep a paper copy of the form in the patient's medical record.

Copies of the forms are available from Medicaid from the following sources.

- Contact the Provider Communications Unit at 800/392-0938 or 573/751-2896.
- Go to the Medicaid website, www.dss.mo.gov/dms, and select and click on "forms" under Provider Information.
- Use the Infocrossing order form found at the end of this section.



STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES

PSYCHOLOGICAL SERVICES REQUEST FOR PRIOR AUTHORIZATION

Authorization approves the medical necessity of the requested service only. It does not guarantee payment. The recipient must be Medicaid eligible on the date of service.

RECIPIENT NAME (LAST, FIRST, M.I.)	DATE OF BIRTH	PROVIDER NAME (AFFIX LABEL HERE)
RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	MEDICAID NUMBER	ADDRESS
<input type="checkbox"/> INITIAL REQUEST <input type="checkbox"/> *CONTINUED TREATMENT		MEDICAID PROVIDER NUMBER

PROVIDER TELEPHONE NO.	PROVIDER FAX NO.	SIGNATURE	DATE
------------------------	------------------	-----------	------

- Has the patient/guardian agreed to his/her treatment plan? ☐ Yes ☐ No
- Have you communicated with the PCP or other relevant health care practitioners about treatment? ☐ Yes ☐ No ☐ No Release ☐ No PCP
- Are you requesting Family Therapy be conducted? ☐ Yes Provider# _____ ☐ No
- Are you requesting Group Therapy be conducted? ☐ Yes Provider# _____ ☐ No
- Are you requesting assessment hours? ☐ Yes Hours _____ ☐ No
- Are you requesting diagnostic testing? ☐ Yes Hours _____ ☐ No

DSM-IV-TR MULTIAXIAL DIAGNOSIS (PLEASE COMPLETE)

AXIS I: CLINICAL DISORDERS OR OTHER CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTIONS

DIAGNOSTIC CODE	DIAGNOSTIC CODE
-----------------	-----------------

IS THERE ANY EVIDENCE OF SUBSTANCE ABUSE?

☐ Yes ☐ No

AXIS II: PERSONALITY DISORDERS, MENTAL RETARDATION

DIAGNOSTIC CODE	DIAGNOSTIC CODE
-----------------	-----------------

AXIS III: GENERAL MEDICAL CONDITIONS

DOES THIS PATIENT HAVE A CURRENT GENERAL MEDICAL CONDITION THAT IS POTENTIALLY RELEVANT TO THE UNDERSTANDING OR MANAGEMENT OF THE CONDITION(S) NOTED IN AXIS I OR II?

☐ Yes ☐ No If Yes, list condition: _____

AXIS IV: PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS (PLEASE INDICATE ALL THAT APPLY)

- | | |
|--|--|
| <input type="checkbox"/> Problems with primary support group | <input type="checkbox"/> Economic problems |
| <input type="checkbox"/> Problems related to social environment | <input type="checkbox"/> Educational problems |
| <input type="checkbox"/> Problems with access to health care services | <input type="checkbox"/> Occupational problems |
| <input type="checkbox"/> Other psychosocial and environmental problems | <input type="checkbox"/> Housing problems |
| <input type="checkbox"/> Problems related to interaction with legal system/crime | <input type="checkbox"/> None |

AXIS V: GLOBAL ASSESSMENT OF FUNCTIONING SCALE (GAF)

SCORE	DATE
-------	------

SERVICE INFORMATION								FOR STATE USE ONLY	
(This area to be used only if the patient is between the ages of 0-2 or if Family Therapy without the patient present)								APPROVED	DENIED
REF. NO.	PROCEDURE CODE	MODIFIER 1	MODIFIER 2	FROM	THROUGH	DESCRIPTION OF SERVICE/ITEM	QTY. OR UNITS		
1									
2									
3									

* Requires an initial assessment, treatment plan and the last three progress notes. Continued treatment requests may only be made after 75% of the current PA is used.

MO 886-4140 (9-04)

INSTRUCTIONS FOR COMPLETION

HEADER INFORMATION

Recipient Name – Enter the recipient's name as it appears on the Medicaid ID card.

Date of Birth – Enter the recipient's date of birth.

Provider Name – Attach a Medicaid provider label or enter the requested provider's information exactly as it appears on the label.

Recipient Address – Enter the recipient's current address.

Medicaid Number – Enter the recipient's 8-digit Medicaid identification number as shown on the Medicaid identification card or county letter of eligibility.

Provider Address – If a Medicaid provider label is not used, enter the complete mailing address in this field.

Initial Request/Continued Treatment – Mark *Initial* for the first Prior Authorization (PA) requested after the 4 hours service without PA. Mark *Continued Treatment* for any PA requested after the initial PA. After the initial/first PA, the second and all future requests require copies of the original assessment, the treatment plan, and the last three progress notes attached to the Prior Authorization Request Form.

Medicaid Provider Number – If a Medicaid provider label is not used, enter the provider's Medicaid Identification number.

Provider Phone – Enter current phone number of the provider making the request.

Provider Fax Number – Enter the fax number of the provider making the request.

Signature/Date – The provider of services should sign the request and indicate the date the form was completed.

QUESTIONS NUMBER 1 THROUGH 6 MUST BE COMPLETED. A SEPARATE PA MUST BE REQUESTED FOR NUMBERS 3 AND 4. HOURS FOR ASSESSMENT AND DIAGNOSTIC TESTING MUST BE LISTED IN ORDER TO BE REIMBURSED.

DSM-IV-TR MULTIAXIAL DIAGNOSIS MUST BE COMPLETED

Axis I – Clinical Disorders

Axis II – Personality Disorders, Mental Retardation

Axis III – General Medical Conditions

Axis IV – Psychosocial and Environmental Problems

Axis V – Global Assessment of Functioning

SERVICE INFORMATION – This field is only to be used for psychological services for children under 3 years of age and Family Therapy without Patient Present.

- 1). Ref. No. – (Reference Number) A unique designator (1-4) identifying each separate line on the request.
- 2). Procedure Code – Enter the behavioral therapy procedure code being requested here.
- 3). Modifier 1 and Modifier 2 – If appropriate, enter the modifier that goes with the corresponding procedure code here.
- 4). From – Enter the from date that service will begin if authorization is approved (mm/dd/yy format).
- 5). Through – Enter the through date that the service will terminate if authorization is approved (mm/dd/yy format).
- 6). Description of Service/Item – Enter a specific description of the service/item being requested.
- 7). Quantity or Units – Enter the quantity or units of service/item being requested.

STATE USE ONLY – Leave Blank

Prior authorization request may be phoned, faxed or mailed into the call center (see below)

Verizon
P.O. Box 4800
Jefferson City, MO 65102
Phone (toll free) 866-771-3350
Fax 573-635-6516



MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
MISSOURI MEDICAID INSURANCE RESOURCE REPORT

TPL-4

Submit this form to notify the Medicaid agency of insurance information that you have verified for a Medicaid recipient. Please send the completed form to:

Department of Social Services
Division of Medical Services
Attention: TPL Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

DO NOT SEND CLAIMS WITH THIS FORM. YOUR CLAIM WILL NOT BE PROCESSED FOR PAYMENT IF ATTACHED TO THIS FORM.

PROVIDER IDENTIFICATION NUMBER

DATE (MM / DD / YY)

PROVIDER NAME

CHECK THE APPROPRIATE BOX FOR THE REQUESTED ACTION



ADD NEW RESOURCE

OR



CHANGE MEDICAID RESOURCE FILES

RECIPIENT NAME

MEDICAID I.D. NUMBER

INSURANCE COMPANY NAME

POLICYHOLDER (IF OTHER THAN RECIPIENT)

POLICYHOLDER'S SOCIAL SECURITY NUMBER

POLICY NUMBER

GROUP NAME OR NUMBER

VERIFIED INFORMATION

SOURCE OF VERIFIED INFORMATION:



EMPLOYER



INSURANCE COMPANY

TELEPHONE NUMBER OF CONTACT

DATE CONTACTED (MM / DD / YY)

()

NAME OF PERSON COMPLETING THIS FORM

TELEPHONE NUMBER

Do you want confirmation of this add/update?

(If yes, you must complete the name and address on back)

☐ YES

☐ NO

ATTACH A COPY OF AN EXPLANATION OF BENEFITS OR INSURANCE LETTER IF AVAILABLE

TO BE COMPLETED BY THE PROVIDER

If confirmation of this add/update is requested, please write the name and address of the person the confirmation should be sent to below. The TPL Unit will complete the bottom portion of this form and mail to the address shown.

TO BE COMPLETED BY THE STATE

☐ Verification and correction as requested completed Date: _____

Insurance Begin Date: _____ Insurance End Date: _____

☐ Please resubmit claims

☐ Form not complete enough for verification by state - complete highlighted areas and resubmit

☐ TPL file already reflects the add/update. Our records were updated: _____

☐ Verification confirms Medicaid resource file correct as is - no update performed

☐ Change requested cannot be made. Reason:

☐ Verification shows another current coverage that may be applicable:

☐ Other: _____



MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

APPLICATION FOR PROVIDER DIRECT DEPOSIT

PLEASE TYPE OR PRINT IN BLACK INK		***SEE INSTRUCTIONS ON REVERSE SIDE***	
SECTION A (All providers must complete this section)			
1. TYPE OF DIRECT DEPOSIT ACTION ➡ <input type="checkbox"/> New provider/Re-enrollment <input type="checkbox"/> Cancel Direct Deposit <input type="checkbox"/> Change Account/Route number			
2. PROVIDER NAME: Complete provider name below as shown on provider labels. If the Application for Provider Direct Deposit is for a clinic or group, this form must be accompanied by an Authorization by Clinic Members which must contain a list of the provider name(s) and number(s) of all Advanced Practice Nurses, CRNA's, Physicians, and Diabetes Self-Management Training providers employed at that clinic/group, along with the ORIGINAL signature of the clinic owner or administrator. All other providers MUST complete a separate Application for Provider Direct Deposit containing their individual provider number and original signature. The clinic Application for Provider Direct Deposit will not be processed without the completed Authorization by Clinic Members. A separate Application for Provider Direct Deposit must be completed for each provider number assigned.			
TYPE OR PRINT PROVIDER NAME HERE ➡ _____			
3. PROVIDER NUMBER (enter provider number as shown on provider label, one provider number per application) _____			
SECTION B (Complete this section if you wish to enroll in direct deposit OR a change in account/route number(s) is requested.) (ATTACH a voided check showing the routing/account numbers, OR if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution completed below. The information completed on this form and the information on the attachment MUST match.)			
1. ROUTING NUMBER _____	2. DEPOSITOR ACCOUNT NUMBER _____		
3. TYPE OF ACCOUNT (must check one) ➡ <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS			
4. FINANCIAL INSTITUTION NAME _____		5. BRANCH NUMBER OR NAME (if applicable) _____	
6. FINANCIAL INSTITUTION ADDRESS _____		7. TELEPHONE NUMBER (include area code) _____	
SECTION C			
I wish to participate in Direct Deposit and in doing so:			
<ul style="list-style-type: none"> ◆ I understand that in endorsing or depositing checks that payment will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State laws. ◆ I hereby authorize the State of Missouri to initiate credit entries (deposits) and to initiate, if necessary, debit entries (withdrawals) or adjustments for any credit entries made in error to my account designated above. ◆ I understand that the State of Missouri may terminate my enrollment in the Direct Deposit program if the State is legally obligated to withhold part or all payments for any reason. ◆ I understand that the Division of Medical Services may terminate my enrollment if I no longer meet the eligibility requirements. ◆ I understand that this document shall not constitute an amendment or assignment, of any nature whatsoever, of any contract, purchase order or obligation that I may have with an agency of the State of Missouri. 			
I am authorized to request Direct Deposit on behalf of this clinic/group and in doing so:			
<ul style="list-style-type: none"> ◆ I acknowledge that each individual in the clinic/group listed on the attached Authorization by Clinic Members has been informed of this request, and also informed that Medicaid funds will be sent to the depositor account specified above. ◆ I understand that each individual provider is responsible for all services provided and all billing done under the individual or clinic provider number, regardless to whom the reimbursement is paid. It is each individual provider's responsibility to use the proper billing code and indicate the length of time actually spent providing a service, regardless to whom the reimbursement is paid. 			
1. <input type="checkbox"/> I HEREBY CANCEL MY DIRECT DEPOSIT AUTHORIZATION and authorize future payments to be sent to the current payment name and address recorded in the provider enrollment file. (Section A number 1 must also be completed)			
2. PROVIDER ORIGINAL SIGNATURE (see requirements on reverse side of this form)	TYPE OR PRINT NAME SIGNED & TITLE	3. DATE	4. TELEPHONE NUMBER
RETURN ORIGINAL FORM (and original Authorization by Clinic Members, if applicable) ALONG WITH A VOIDED CHECK OR LETTER FROM YOUR BANK (see Section B) TO: Division of Medical Services, Provider Enrollment Unit, PO Box 6500, Jefferson City MO 65102. Phone 573-751-2617			

THIS FORM CANNOT BE FAXED

APPLICATION FOR PROVIDER DIRECT DEPOSIT INSTRUCTIONS

SECTION A ***ALL providers must complete this section***

- 1. Type of Direct Deposit Action** - Check appropriate box. **If canceling direct deposit you must also complete Section C, #1.**
2. & 3. Provider Name and Provider Number - Enter provider name and number **EXACTLY** as shown on your provider label.

SECTION B ***This section must be complete for new applicants or re-enrollments and any changes to your direct deposit information.

ATTACH a voided check showing the routing/account numbers, **OR** if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution **to the back of this form**. The information completed on this form and the information on the attachment **MUST** match.

- 1. Routing Number** - Enter your financial institution's routing number as printed on the bottom left portion of your business checks or deposit tickets (the first 9 digits). See Examples 1 and 2 below.
- 2. Depositor Account Number** - Enter depositor account number as printed on the bottom of business checks following the routing number. It may be the first series of digits after the routing number followed by your check number (example 1) or it may be the series of digits which follow your check number (example 2). NOTE: The check number is not included in the depositor account number.

EXAMPLE 1

FINANCIAL INSTITUTION HOMETOWN, USA		CHECK NO. 4444
PAY TO ORDER OF _____		
121456789	8765432109812	4444

EXAMPLE 2

FINANCIAL INSTITUTION HOMETOWN, USA		CHECK 4444
PAY TO ORDER OF _____		
121456789	4444	8765432109812

↑ ↑ ↑
 Routing No. Depositor Acct No. Check No.

↑ ↑ ↑
 Routing No. Check No. Depositor Acct No.

*****Credit Unions and Savings and Loan Associations may differ from the above examples. Please VERIFY your DEPOSITOR ACCOUNT NUMBER and ELECTRONIC ROUTING NUMBER with your financial institution.*****

SECTION C

- 1. TO CANCEL OR REDESIGNATE:** Complete and submit a new Application for Provider Direct Deposit with the changed information and forward to the Division of Medical Services. **You must check the CANCEL box if you wish to CANCEL your direct deposit, Section A number 1 must also be completed.** If you elect to cancel direct deposit future payments will be sent to the current payment name and address recorded in the provider enrollment file. Provider direct deposits will continue to be deposited into the designated account at your financial institution until the Division of Medical Services is notified that you wish to **cancel or redesignate** your account and/or financial institution.
DO NOT CLOSE AN OLD ACCOUNT UNTIL THE FIRST PAYMENT IS DEPOSITED INTO YOUR NEW ACCOUNT.
- 2. PROVIDER SIGNATURE** - If the provider is enrolled as an individual, he/she must sign the form. Nursing homes, hospitals, independent laboratories and home health agencies must be signed by a person listed on form HCFA-1513 (disclosure of ownership) section III (a). If enrolled as a clinic or business (except those listed above) the form must be signed by the person with fiscal responsibility for the same. **Clinic applications must be accompanied by the Authorization by Clinic Members which must contain a list of the name(s) and provider number(s) of all Advanced Practice Nurses, CRNA's, Physicians, and Diabetes Self-Management Training providers employed at that clinic location. The Application for Provider Direct Deposit and the Authorization by Clinic Members MUST be signed by the same person. All other providers must complete a separate Application for Provider Direct Deposit containing their individual provider number and original signature. A SEPARATE FORM MUST BE COMPLETED FOR EACH PROVIDER NUMBER ASSIGNED.**

OTHER

- 1. ATTACH** a voided check showing the routing/account numbers, **OR** if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution **to the back of this form**. The information completed on this form and the information on the attachment **MUST** match.
- Direct deposit will be initiated after a properly completed application form is approved by the Division of Medical Services and the successful processing of a test transaction through the banking system.
- This form must be used to change** any financial institution information **or to cancel** your election to participate in direct deposit.
- The Division of Medical Services will terminate or suspend the direct deposit option for administrative or legal actions including, but not limited to, ownership change, duly executed liens or levies, legal judgements, notice of bankruptcy, administrative sanctions for the purpose of ensuring program compliance, death of a provider and closure or abandonment of an account.
- If any information completed on this form cannot be verified from the attachments or the form is completed incorrectly, the form(s) will be returned without being processed for direct deposit.

Forms Request

Provider Number: _____
(Or Affix Provider Label Here)

Date: _____

Provider Name: _____

Provider Phone: _____

CLAIM FORMS	Quantity	
	Preprinted	Blank
A. Pharmacy		
B. Dental		
C. HCFA 1500 (Rev 12/90)		
D. HCFA 1450 (UB-92) Inpatient / Outpatient/ Home Health		
F. Prior Authorization		

CROSSOVER STICKERS

G. Hospital Crossover Sticker (BLACK)	
H. SNF Crossover Sticker (RED)	
I. Part B Crossover Sticker (BLUE)	

If provider labels are needed with blank Claim Forms (A-F), check box. ☐

If you checked box, an equal number of labels will be supplied with Forms A-F. If you DID NOT check box, you WILL NOT receive labels.

If provider labels are needed and you are not ordering Forms A-F, indicate the quantity _____

SPECIAL MAILING INSTRUCTIONS:

Name: _____

Attn: _____

Street Address: _____

(Not P.O. Box)

City: _____

State: _____ Zip: _____

ADDRESS CHANGE / CORRECTION:

Provider Number: _____

Name: _____

Street Address: _____

(Not P.O. Box)

City: _____

State: _____ Zip: _____

Effective Date of Change: _____

ATTACHMENTS

Quantity

J. HCY Medical Screening Tool (All Pages)	
HCY Screening Forms by Age Group	
2. Newborn - 1 month/2 - 3 months	
3. 4 - 5 months/6 - 8 months	
4. 9 - 11 months/12 - 14 months	
5. 15 - 17 months/18 - 23 months	
6. 24 months/3 years	
7. 4 years/5 years	
8. 6 - 7 years/8 - 9 years	
9. 10 - 11 years/12 - 13 years	
*. 14 - 15 years/16 - 17 years	
&. 18 - 19 years/20 years	
K. HCY Lead Risk Assessment Guide	
L. Sterilization Consent	
M. Acknowledge Hysterectomy	
O. Hearing Aid Evaluation	
P. Medical Necessity	
Q. Adjustment Request	
R. Medical Necessity Long Term HPN	
S. Second Surgical Opinion	
T. Medical Necessity - Abortion	
U. Hospice Election Statement	
V. Oxygen - Respiratory Justification	
W. Notification of Termination of Hospice Benefits	
Y. Insurance Resource Report (TPL-4)	
Z. Accident Reporting Form (TPL-2P)	
1. Physician Certification of Terminal Illness	

* Provider Signature: (Must Be Provider's Original Signature)

All requests are delivered to the address on your current provider label unless an address change or correction is requested above. An address change or correction changes your provider billing label. If Special Mailing Instructions are indicated, this and all future requests for forms from Verizon Data Services are delivered to this address until notice of a change is received. A change to Special Mailing Instructions does not change your provider billing label.

The above forms are provided to all participating Missouri Medicaid Providers. They are intended solely for Missouri Medicaid claims filing. Please complete the above information and return it to Verizon Data Services via any paper claims submission P.O. Box. For information regarding electronic claims submission, contact Verizon Data Services at (573) 635-3559.

DS1054 (Rev. 11/00)

NONDISCRIMINATION POLICY STATEMENT

The Missouri Department of Social Services (DSS) is committed to the principles of equal employment opportunity and equal access to services. Accordingly, DSS shall take affirmative action to ensure that employees, applicants for employment, clients, potential clients, and contractors are treated equitably regardless of race, color, national origin, sex, age, disability, religion, or veteran status.

All DSS contracts and vendor agreements shall contain non-discrimination clauses as mandated by the Governor's Executive Order 94-3, Article XIII. Such clauses shall also contain assurances of compliance with Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended/ the Americans with Disabilities Act of 1990 (ADA), as amended; the Age Discrimination Act of 1975, as amended and other pertinent civil rights laws and regulations.

Applicants for, or recipients of services from DSS who believe they have been denied a service or benefit because of race, color, national origin, sex, age, disability or religion may file a complaint by calling the DSS Office for Civil Rights at 1-800-776-8014. Complaints may also be filed by contacting the local office or by writing to:

Missouri Department of Social Services
Office for Civil Rights
P. O. Box 1527
Jefferson City, MO 65102-1527

Or

U.S. Department of Health and Human Services
Office for Civil Rights
601 East 12th Street
Kansas City, MO 64106

Additionally, any person who believes they have been discriminated against in any United States Department of Agriculture related activity (e.g. food stamps, commodity food, etc.) may write to the United States Department of Agriculture at:

USDA Office of Civil Rights
1400 Independence Ave., SW
Mail Stop 9410
Washington, DC 20250

This policy shall be posted in a conspicuous place, accessible to all applicants for services, clients, employees, and applicants for employment, in all divisions, institutions and offices governed by DSS.



Director, Department of Social Services

2004
Year